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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD
Wednesday, January 8, 1997
1380 Howard Street, 4th Floor Conference Room
7:00 p.m.

AGENDA:

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I. CALL TO ORDER, INTRODUCTIONS

5 min. **II. CONSENT CALENDAR**
- Approval of November, 1996 Minutes

60 min. **III. SPECIAL PRESENTATION: AIDS/HIV AND MENTAL ILLNESS**
Roy Crew, Director, Office of Self Help; Mitchell Katz, M.D., Director, S.F. AIDS Office; Jonathan William Brown, Director, Brothers' Network

15 min. **IIIa. MHB DISCUSSION OF PRESENTATION**
- Including possible action

20 min. **IV. MHB COMMITTEE REPORTS**
- Executive Committee: Future Agenda Topics
- Program and Services Committee
- Public Relations/ Children's Committee
- Consumer/Family Member Task Force
- Provider Advocacy Group
- MHB Representatives to Other Groups

15 min. **V. REPORT OF THE DEPUTY DIRECTOR**

5 min. **VI. PUBLIC COMMENT:** An opportunity for members of the public to comment on issues under the MHB's purview; for which there has not been a chance to comment earlier in the meeting.

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exits to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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MHB ACCESSIBLE MEETING POLICY

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AIDS/HIV and Mental Health

Join us for a panel presentation featuring:

Roy Crew
Director
Office of Self Help

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Mitchell Katz, M.D.
Director
AIDS Office
San Francisco Department of Public Health

Jonathan William Brown
Director
Brothers' Network

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at the regular meeting of the
Mental Health Board of San Francisco
at 7 p.m. on Wednesday, January 8, 1997
in the 4th Floor Conference Room
at 1380 Howard Street (at the corner of 10th Street)
San Francisco

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UNADOPTED MINUTES

Wednesday, January 8, 1997, 7 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Acting Chair); Teri A. Adams, J.D.; Darwin Dias; Lois A. Jones; Toye Moses, Ph.D., M.P.H.; Alex Rossman, M.S.W.; Mickey Shipley; Phyllis Spanglet.

BOARD MEMBERS ON LEAVE: Norma Block (Chair); Anita Burton; Peggy Gilleran, J.D.; Paula Wilson.

BOARD MEMBERS ABSENT: Lora Traveler.

ADJUNCT BOARD MEMBERS PRESENT: none

PRESENTERS: Roy Crew, Director of the Office of Self Help; Mitchell Katz, M.D., Director of the AIDS Office, San Francisco Department of Public Health; Jonathan William Brown, Interim Director of the Brothers Network.

OTHERS PRESENT: Jo Ruffin (DMS); Mike Wise (Consumer; Residential Care Task Force); Mrs. Lillian Wise (Family Member); Art Fogel (Consumer); Consuelo Perez Moore (Office of Self Help, Consumer); Amelia Truman (Coordinator, Community Advisory Board); Ann Grant (Coordinator, Community Advisory Board); Mark Adamek (Spiritmenders, Community Advisory Board); Lorraine Killback (Westside Community Mental Health Center); Tatiana A. Kostanian (MOHNA International, Center for Victims of Trauma with Disabilities); Carole Gray; Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Acting Chair, at 7:00 p.m.
Ms. Leib introduced Mickey Shipley, a new member of the Mental Health Board who was appointed by Supervisor Angela Alioto. Mr. Shipley introduced himself as follows: I've been in the system for 12 years. I'm a consumer and a family member. My mother is manic depressive and my daughter is depressive. Since 1998, I've been a consumer activist. I was a peer counselor through the BUILD program for 7 years with Carol Patterson. Two and a half years ago I got a job working in the system. I no longer work in the system, and now wear a lot of different hats working with different organizations. I try to be concerned with consumer and family member issues in a

major way. With regard to the MHB, I consider myself a consumer representative, and am looking forward to serving my tenure on the Board.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-01): Be it resolved that the minutes of the Mental Health Board meeting of November 13, 1996, be approved as submitted. (Passed)

III. SPECIAL PRESENTATION:

Ms. Leib introduced Mr. Brown as the Interim Director of the Brothers Network. Mr. Brown made the following presentation: Thank you for inviting me and giving African American people a voice and a seat at the table. Brothers Network started 7 years ago. It grew out of the National Task Force on AIDS Prevention and the group Black and White Men Together.

We serve African American gays, transgender people, and questioning youth. Most African Americans who are transgender, are male to female. A lot of times these people are dealing with passing issues, and not being identified or "clocked."

One example of the clients we work with where we had to confront mental health issues was a person dealing with relationship and abuse issues. In 6 months he had gone from a well-kept person to not being able to walk on his own. He was not disclosing that he had AIDS. We didn't know if he was suffering from dementia or substance abuse. He lost control of his bowels in my office. This was not a situation we were prepared to handle on our own. We called for emergency medical assistance. This was startling for us as a community-based organization.

We are on the AIDS Planning Council, and it is hard getting funding for services for transgender people. It's clear to us that more funding is needed for this particular population in terms of mental health services.

Ms. Leib introduced Dr. Katz who holds the following positions in the Department of Public Health in San Francisco: Director of the AIDS Office; Director, Epidemiology, Disease Control, and AIDS; Deputy Health Officer; and Interim Medical Director, Emergency Medical Services. He is also Assistant Clinical Professor of Medicine, Epidemiology, and Biostatistics, University of California, San Francisco, and the author of numerous journal articles.

Dr. Katz made the following presentation: I'd like to take a few minutes to tell you what the AIDS Office does and then hear your suggestions for how we could improve our work.

The Office was formed in 1984 to coordinate AIDS services. It was felt that the bureaucracy of the Department of Public Health couldn't move fast enough to deal with the emerging crisis. Now we are moving back into the Department to make sure AIDS treatment occurs in the context of other health issues.

The Office serves as a conduit for federal and other funding. We give it mostly to community-based organizations, and in some cases DPH programs. On the prevention side, we focus on working with people already in our system, and we work on how to improve people's mental health generally so they will be less likely to take risks. People with a strong sense of their own identity and with a clear meaning to their lives are less likely to take risks.

With regard to AIDS and mental health, there are three issues: 1) People with long-standing mental illnesses who then become HIV-infected. 2) People who were doing well in their lives but HIV was that one last thing that was too much, and now they are dealing with mental health issues. 3) People who have advanced HIV and are suffering from dementia. With AIDS this is primarily an intellectual loss, but it can also be an emotional loss.

Our goal, which we've achieved in some senses is to make services available where clients go. We don't want AIDS services to be separated out. A good model of integrated services is at Health Center #1 where both psych and medical services are located together.

Ward 86 at San Francisco General Hospital is where the largest number of HIV-infected patients are. We've placed a psychiatrist there to work with people on that ward. That's the kind of model we want. We also have crisis programs for nights and weekends. The challenge we'll continue to pursue is how to create a model that puts the services where the people are.

Ms. Leib introduced Mr. Crew who is the Director of the Office of Self Help, a former member of the Mental Health Board, a founder of the Consumer/Family Member Task Force of the MHB, and who has been asymptomatic for 11 years since his original diagnosis as HIV-positive.

Mr. Crew made a presentation as follows: My situation is medically complex. I have been HIV-positive but asymptomatic for 11 years. I had mental illness and substance abuse problems. I'd like to show you the daily regimen of medications and supplements which I take.

Mr. Crew then place about two dozen bottles on the table and detailed what each medication and supplement was for, indicating that some of the medications were needed to help counteract the unwanted effects of some of the other medications. He noted: Still on a daily basis I am confronted with voices which tell me I'm not going to make it, the command voices, and also the voices saying: You are going to make it.

He commented further: Accurate assessment is extremely important so you will know if someone shows up with psychosis, whether it is drug-induced psychosis, AIDS dementia, or mental illness.

With regard to the AIDS test, today's tests are much better than in past years. Now they test your blood 5 times, and consider you positive if 3 or more of those tests are positive. However, some people who are positive don't test positive.

The medications for treating AIDS are also much improved, especially with the protease inhibitors. So early testing is now more important than ever. Eleven years ago I took the test and am still alive. In the meantime, three sets of my friends who didn't get tested are dead.

How do I cope? I'm a Buddhist. This morning I was filling water bowls on my shrine. From a front view they looked like they were full, but when I looked at them from the side, they weren't full. It was a matter of perspective. If I allow myself to, I will become my diagnosis. I don't want to be confronted with AIDS or mental illness 24 hours a day. I keep my AIDS medications out of sight so my friends aren't thinking all the time, "Roy is sick, poor Roy."

I'm not my illness, I'm Roy Crew.

Weekly we get calls from people who are so confused by what they've heard from 12-step programs, or their AIDS doctor, or their therapist about what they should be taking. We tell them to gather up all their medications and take them to their doctor and have them review everything at the same time to make sure there are no bad cross reactions. Also to review if they really need to be taking all of those medications, to make sure people aren't taking any unnecessary medications.

I'm glad to see the Brothers Network here. It wasn't cool to come out and say I'm gay in the African American community. And still isn't.

A study at SFGH on Ward 7B showed that 52% of people on 7B had a previous psychiatric history; and 50-85% had substance abuse problems in their past. Lots of clients act out sexually. Drugs and medications both can push your libido through the ceiling. It's important to make sure we take the effects of the medications into account.

It's important to make sure people don't see themselves as just their illness.

Ms. Jones: In 1996, I lost three clients, all African American moms, also friends, who had a total of 11 kids. None of these women got themselves tested in time. And then another woman calls and tells me she's got AIDS and she's got kids. Some of these moms have 5 kids with 4 different fathers. I'm tired already and it's only happened to me 3 times. What is the AIDS Office doing with regard to women of color with children, which is the fastest rising AIDS population?

Dr. Katz: There is no simple answer for the problem of women with AIDS. Women will generally attend to the needs of their kids and their partners before themselves. We've

started running the women's and children's clinics at the same time, so women can be seen and treated at the same time as their children. It used to be women would bring their children but then not come back at another time for themselves.

We've tried to increase transportation, using taxi vouchers, because it is not sensible to ask women with 3 children to take the bus.

For housing, we use subsidies, because independent housing is best for families, whereas we use residences for single people.

We've done a lot but there is so much more to do.

The new drugs are very different than the old drugs. I never knew anyone who felt better after taking AZT, they just got sick at a slower rate. The new drugs have not helped everyone, but for others dramatic changes have happened, there are people who were near death, or who were disabled, who are now back to work.

The new drugs may help moms be able to live longer. Hope is important. Unlike before, now there really is something better. And it might make the difference, might allow a mom to see her kids graduate from high school.

Ms. Jones then brought up the cuts being proposed by Governor Wilson.

Dr. Katz responded: There are complaints about the millions that San Francisco and Los Angeles get for AIDS, but per person who is sick we get less money than some of the rural counties.

Mr. Brown: I'm very touched by what Lois said. Partners of our clients have asked us, "Where's the Sisters Network?' and we didn't have it. We are limited by our Mission Statement which says we are to advocate for African American men. And the Womens Aids Network lost its funding. We need to advocate for funding for women at all stages of their lives.

Mr. Crew: We need to really bring these services into the community. Why not have a child care program that goes to the homes of the women who need it.

I'd like to know why the mental health programs aren't listed in the HIV seroreport.

There are 17,000 mental health clients in the DMS system. It would be nice to have an anonymous survey to gather information to give us an idea what percentage is at risk, tested, exposed, exposed to education, etc.

The AIDS Office and DMS ought to get together to fund peer-run education programs. If 50% of mental health clients are using drugs, then they are perhaps at risk.

Ms. Ruffin: I agree with you, Roy, and I think you make a very good point. Some of our outcome measures are starting to look at the full range of health issues including AIDS, and many of these health issues are neglected, just as with AIDS.

Mr. Wise: I'm wondering if psychotropic medications are contradictory to AIDS medications? I had devastating physical side effects from my medications until I got on the right one.

Dr. Katz: People are very individual and how they react to medications is individual. What is wonderful for one person is not for another. Most of the psychotropic medications are okay with AIDS medications. But the protease inhibitors are different. They are broken down in the liver and will speed up or slow down reactions of other drugs. Most clinicians are able to find a combination that works, but it's individual. There is no plan that works for everyone.

Mr. Brown: We try to get psych assessments done, but how much of a person's life can you get in an assessment? Most of our clients have no support. They have left their homes to come to San Francisco. I feel a support system plays a large part in people's lives. We do a lot around food and eating. Once a month we have a potluck meeting for mutual support. We give people options to choose from because we want to empower people.

Mr. Crew: If people call the Office of Self Help, we will help them set up an appointment for testing, we'll go with them to the test, and give them counseling and follow up.

Dr. Moses: AIDS is very common among African Americans, but there is only one residential program for African Americans in San Francisco, Rafiki House. Dr. Katz: We've found that people tend to prefer getting subsidies so they can live in their own apartments or houses. So we've been shifting away from building residences to providing subsidies. I believe the Ark of Refuge has a program for women, and I'm not sure if they take children as well.

IIIa. DISCUSSION OF PRESENTATION

Ms. Leib: I liked the idea of a survey. It seems to me something the Board should address. Specifically, let's look at the clients we currently serve and if half are substance abusing, then they are at risk, and why wait till the problem explodes in the hospital.

Ms. Ruffin: Let me check on what's available and what we could do in that regard and report back to you next meeting.

Ms. Jones: People I knew went to the hospital for other problems and in the course of testing found out they were HIV-positive.

Ms. Rossman: If for some reason the survey is too expensive, at least could DMS do some kind of education sheet to be distributed to clients telling them about the importance of getting tested early and the information about the new drugs?

Ms. Ruffin: Let me tell you a little about the 17,000 clients in the system, which is an increase of 10% over last year. Fourteen thousand of them are adults, 3,000 are seniors and children. The concomitant abuse of substances tends to be with the adults. This is especially high in the clients who end up in involuntary treatment. We've done a tremendous amount of education about AIDS with staff and clients, but what is different now is the new motivation for testing.

IV. MHB COMMITTEE REPORTS

Executive Committee
Ms. Leib asked Board members to review Attachment A, regarding presentations for future Board meetings and to submit any recommendations they have for presentation topics.

Ms. Jones announced the candidates chosen by the Nominating Committee for MHB officers for the 1997 term. The nominations are: for Chair, Norma Block, for Vice Chair, Maria Leib, for Secretary, Toye Moses. The election will be held at the February meeting.

Program and Services Committee
No report.

Public Relations Committee
Ms. Leib announced that it was expected that the Art Commission would approve the exhibit to be sponsored by the Mental Health Board and to take place at City Hall in May and June.

Children's Committee
Ms. Jones announced the upcoming meeting which is to focus on Transition Services for youth from ages 16-22.

Consumer/Family Member Task Force
No report.

Provider Advocacy Group
Ms. Rossman reported that a meeting had been called in December but that apart from Jo Ruffin no providers showed up. She said that she and Tony Tape and Mary Sue Planck had discussed the possibility of putting out a newsletter to reach providers. Ms. Ruffin noted that there have been a lot of planning meetings at DMS which providers are participating in. She suggested the possibility of combining PAG and planning meetings.

Community Advisory Board
Mr. Dias said that the Department of Psychiatry reported on their philosophy of treatment. He said that PES is being restructured to make it more user friendly, including more limitation of the use of restraints and seclusion. He noted that Dr. Francis Lu had given a very interesting talk on diversity and cultural competency.

Ms. Leib announced that this meeting was the last for Board Member Phyllis Spanglet, who has served two full terms. Ms. Leib thanked her for her contributions to the work of the Board.

Ms. Spanglet: There's something I want to say. How can we have someone appointed to the Board for 5 months who has not attended one meeting? We need to have people appointed to the Board who are willing to come to meetings.

Dr. Moses: I agree with you and suggest that the Executive Committee take up this issue. We have too many appointees who don't show up.

Ms. Leib: I'm glad you brought that up. It's been a burr in my side for a long time.

Ms. Spanglet: I have been on the Board for six and a half years and have not missed one meeting, and that's not something that should be considered extraordinary.

Ms. Ruffin, speaking to Ms. Spanglet: On behalf of the Division I would like to thank you for all your work on our planning committees. Even though you will be off the Board I hope you'll still be active in the community and we'll be able to call on you.

V. REPORT OF THE DEPUTY DIRECTOR
Ms. Ruffin called attention to a letter the Board had received from her requesting time at the February Board meeting to present the plans for outpatient consolidation.

She continued: Of our 17,000 unduplicated clients, about 60% are MediCal and about 40% are indigent. All of them have to meet the criteria for being seriously mentally ill to receive services. The outpatient consolidation gives us responsibility for fee-for-service clients in our county, and broadens eligibility to all MediCal people. But we want a single system of care that includes indigent people. We will be at risk for 125,000 MediCal clients, and it is estimated that there are 150,000 indigent people in San Francisco.

For the past 25-30 years we have been responsible for the high-risk clients. Now we are adding less-high-risk clients. We want to focus on prevention so that we can help people not become clients of the system, so we can prevent mental illness.

We've been planning for 3 Single Point of Responsibility programs. They will be operated by 1) the UCSF Department of Psychiatry at SFGH, 2) Westside, and 3) Mission Day Treatment (which will convert to an SPR.)

These SPR's will be using an intensive case management model. The program has to arrange for coverage for 24 hours a day, 7 days a week. They will each have a pool of funds which they can use to buy services for their clients. So if they need to send a homemaker to the home, they can do that, and not have to go through a long process to make it happen.

We are currently in the budget planning process for the fiscal year starting in July. We are building the SPR's into the budget.

We did a survey of high-user clients and identified them by name. We have 650 who we have never been able to successfully transition to the community. It costs us $23 million for these 650 clients. If we got better at doing the kinds of services we want to do, there will be more money available for other people who also need services.

That's how I like to think of managed care, rather than the way the term is used in other places.

We've put in a specific budget request for an Office of Consumer Affairs and a Director of Consumer Affairs. We have also asked for a basic increase in our budget due to a 10% increase in clients.

With regard to the Mental Health Rehabilitation Facility, the second group of staff has been hired and they will be trained over the next few weeks. The feedback I'm getting about the MHRF is pretty good.

Regarding an advisory group for the MHRF, my point of view is that the Mental Health Board is the official advisory Board. I would like your input about that and whether there should be a separate advisory group. Staff has been very involved with getting feedback from clients and family members.

Supervisor Sue Bierman is ready to move ahead with the Repeal of the Site Approval Ordinance. I would like your advice about whether you favor modification of the ordinance or complete repeal. I favor complete repeal, because it seems to me the ordinance singles out mental health and substance abuse clients in a discriminatory way.

Ms. Spanglet moved the final resolution of her MHB tenure.

RESOLUTION (MHB-97-02): Be it resolved that the Mental Health Board give its full support to the complete repeal of the Site Approval Ordinance of the City and County of San Francisco which is Section 15.7 of the San Francisco Administrative Code. (Passed)

Ms. Jones: Sixty-Minutes did a program about commercial managed care companies refusing to authorize treatment for their members and so people ended up getting dumped into the public system. We need to address how to stop companies from doing this at least in San Francisco. Someone with $1 million in lifetime benefits should not be dumped into the public sector.

Ms. Ruffin: We're getting more business-like in our evaluation of access to our system. We'll be pursuing private insurance companies to get them to pay for benefits.

Ms. Jones also raised the issue of people not being able to get appropriate medications because the medication they need is not on the MediCal list.

Ms. Ruffin: We've put in a budget request for a major item for medications. MediCal has broadened their formulary and we want to make these new medications available to indigent clients as well. We're just on the verge for the first time in 25 years of a new class of psychotropic medications, which are not cure alls, but much more beneficial and effective. We want these medications to be covered, and we want to be able to give clients the best medication for them right away, not as a last resort.

VI. PUBLIC COMMENT PERIOD

No comments.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:40 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, February 12, 1997
1380 Howard Street, 4th Floor Conference Room
7:00 p.m.

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AGENDA:

10 min **I. CALL TO ORDER, INTRODUCTIONS**

10 min **Ia. WELCOME TO SUPERVISOR SUE BIERMAN**

15 min **II. CONSENT CALENDAR**
a. Approval of January Minutes
b. Support of SPR Programs (See Attachment A)

15 mun **III. ELECTION OF MHB OFFICERS** (See Attachment B)

20 min **IV. COMMITTEE PARTICIPATION** (See Attachment C)

20 min **V. REPORT OF THE DEPUTY DIRECTOR**

20 min **VI. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's, Public Relations
- Program and Services
- Consumer/Family Member Task Force
- Provider Advocacy Group - Disbanded
- SFGH Community Advisory Board
- MHB Representatives to DMS, Other Committees

10 mins **VII. PUBLIC COMMENT PERIOD:** Members of the public will have up to 3 minutes each to speak on any subject within the purview of the MHB, unless there has already been an opportunity for the public to address that same subject earlier in the meeting.

VIII. ADJOURNMENT

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UNADOPTED MINUTES

Wednesday, February 12, 1997, 7 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Norma Block (Chair); Jim E. Beauford, Ph.D.; Supervisor Sue Bierman; Darwin Dias; Lois A. Jones; Maria Leib; Toye Moses, Ph.D., M.P.H.; Alex Rossman, M.S.W.; Mickey Shipley; Lora Traveler.

BOARD MEMBERS ON LEAVE: Anita Burton; Peggy Gilleran, J.D.; Paula Wilson.

BOARD MEMBERS ABSENT: none

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni

OTHERS PRESENT: Jo Ruffin (DMS); Mike Wise (Consumer; Residential Care Task Force); Mrs. Lillian Wise (Family Member); Mark Adamek (Spiritmenders, Community Advisory Board); Emerick Kalman (Family Member); Lorraine Killback (Westside Community Mental Health Center); Ernie Situy (St. Luke's); Carl Word (California Institute of Integral Studies); Mary Sue Planck (MHB Staff); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Ms. Block, Chair, at 7:03 p.m. Ms. Block introduced Dr. Jim Beauford, a new member of the Board, appointed by Supervisor Michael Yaki. Dr. Beauford introduced himself as follows: I have a Ph.D. in Clinical Psychology, with a special focus on children, adolescents, and families. I have 11 years training in mental health, and have been involved in health policy. I look forward to serving with experience and passion.

Ia. WELCOME TO SUPERVISOR SUE BIERMAN

Postponed until the arrival of the Supervisor.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-03): Be it resolved that the minutes of the Mental Health Board meeting of January 8, 1997, be approved as submitted. (Passed)

III. ELECTION OF MHB OFFICERS

The following members were elected to the following offices:

Chair—Norma Block
Vice Chair—Maria Leib
Secretary—Toye Moses

IV. COMMITTEE PARTICIPATION

Ms. Block reported as follows: Committee attendance has not been good. A few people have been doing all the work for the Board. The current committees were formed quite some time ago when the composition of the Board was different. Perhaps the committee structure is not appropriate anymore. I'm going to ask the committee chairs to give a brief overview of their committees.

Ms. Leib reported on Public Relations Committee as follows: We felt it was really vital that we increase public awareness of mental health. We are now holding a major event in the Spring and a smaller event in the Fall. We are doing what I like to call Arts Three in May. Without Rich, who is my right and left hand, we would have very few PR events.

Ms. Jones reported on the Children's Committee as follows: We're not working on the Transition Program. We asked Sai-Ling to go back and ask for a redirection of some of the funds so that there will be programs in place specifically for transition-age people. I'd like to see young people get help and not end up in jail. Ms. Leib added: the PR and Children's Committees jointly put on an Adolescent Health Forum two years ago and last fall focused on the Mayor's Youth Summit.

Ms. Block noted: Ms. Jones is being very modest in describing her work. She's a passionate child advocate.

Dr. Moses reported on the Program and Services Committee: The Program and Services Committee is the best, most exciting, and most active committee. We have invited guest speakers to come and then we make recommendations to the full Board. Ms. Planck added: The other half of the work of the Committee is to go out and do program reviews, interviewing the clients themselves. Ms. Block added: This is one of the most important things we do, and one of the major charges of the Board.

Ms. Block continued: There are all kinds of possibilities, limited only by our interests.

Ms. Rossman reported on the Provider Advocacy Group: In the past providers have come together to talk about issues. Currently there is competition from a meeting for providers that DMS is running. So we are currently talking about the possibility of putting out a newsletter.

Ia. WELCOME TO SUPERVISOR SUE BIERMAN

Ms. Block introduced Supervisor Bierman, appointed by Barbara Kaufman, President of the Board of Supervisors, to be the Supervisor representative on the Mental Health Board: Supervisor Bierman is a good friend to mental health, and has attended many of

our events. She started out as a neighborhood activist. I like to think that her soul is still that of a neighborhood activist, instead of being corrupted like other people in her position might have had happen to them.

Supervisor Bierman commented: I look forward to working with you and I hope I have enough time in my schedule to be of help to you.

V. REPORT OF THE DEPUTY DIRECTOR

We are in the middle of the budget process for 97/98. We have been working in the last several months internally in the Department. There was some paring down of our requests for new funding. The good news is that mental health has not had any cuts, and we're very grateful for that.

We have made some requests for additional funding which will be forwarded to the Mayor next week. We have requested a total of $3 million in new funds for mental health. Of that, $2.5 million will come from new state realignment funds. We've also made a general fund request of $1.6 million. We received special inpatient consolidation money last year. We are asking for equivalent money to replace what's being lost with the ending of that special funding.

We're working very hard in structuring our system for managed care. The Single Point of Responsibility (SPR) programs are being instituted and we are redesigning our system around them. These are partially-capitated programs. Two contract agencies will be starting SPR's and one will be run by the City. They will enroll 400 of the highest-end users. We did an analysis which showed us that there are 600 users of the system who use $23 million in services in one year. We want to reduce inpatient and high-end services. SPR's are responsible for having wrap around services available to their clients 24 hours a day, 7 days a week. So if one of those clients is going through a crisis, they will have people to call. We have not requested any new funding for the SPR's.

We have requested $300,000 for access to managed care, which means the 800 phone number, which will be operable 24 hours a day, 7 days a week.

In relation to the managed care infrastructure I have asked for $180,000 for client outcome measures, credentialling, and quality management.

Outpatient consolidation has been delayed from July 1, 1997, to October 1, 1997. The County will be responsible for all providers now taking fee-for-service MediCal.

We are also requesting computers for the managed care network.

With regard to Consumer Services and Customer Services, we will be hiring a Director of Consumer Affairs, who will also serve as an ombudsman, to work directly under Tina Yee. We will include stipends for additional consumer staff.

We have had a state grant for the development of culturally-competent suicide prevention services, and want to do suicide prevention training with primary care physicians in the Department and the community.

We're requesting additional pharmacy funds and psychiatrist time. We have waiting lists for our med clinics and that's not acceptable. We're requesting 5 additional psychiatrists, 1 additional pharmacist, and funding to pay for the newer drugs for indigent clients. We want to serve indigent clients on the same basis as our MediCal clients.

There are two important things which are not in the budget: 1) There is no contractor COLA. The Mayor's Office asked us to prepare an estimate of a 4% COLA, and that came to $2.9 million. It's not included on our list of requests, but the need is there and recognized. 2) We need to take on indigent clients as well as MediCal. We've made a $2.3 million request so we can serve indigent clients on the same basis as MediCal clients.

I want to thank Steve Leoni who attended the Health Commission meeting and backed me up wonderfully point by point and from a consumer perspective. I want to thank Steve very much for that help.

Contracting begins in 4 months. We'll have specific outcome measures and program review procedures developed.

With regard to the Mental Health Rehabilitation Facility, we're looking at who should be the advisory group for the facility, the Mental Health Board or the Community Advisory Board. And if it's the CAB that's chosen, should there be an MHB representative involved.

There is no specific advisory committee for the SPR's, except that the Leadership Work Group fulfills that role. That is the group that provides oversight for managed care. But in addition the CAB is acting in an oversight role for the SPR at San Francisco General. And Westside also has it's own Board of Directors which will have additional oversight over their SPR.

We are working on developing training for children and families who are at risk of being cut off SSI. We already have been doing training for adults in coordination with the Coalition on Homelessness. We've made a request through Jeff Mori at the Mayor's Office of Children, Youth, and Their Families and the welfare restructuring group.

Ms. Jones noted: The new regulations are out, so families need help now, because the hearings are going to start and checks are going to be cut off. This is happening now.

Ms. Ruffin responded: We have trained all Children's Services staff on reapplying for SSI. But what we are working on now is a larger effort citywide for reaching families.

Ms. Jones added: These checks are how some of these parents are able to keep their children at home rather than them having to be sent to residential facilities.

Ms. Ruffin continued: We are taking advantage of opportunities in our work in the schools to bill MediCal for services. The EPSD funds are entitlement dollars which are coming in from the federal level and give us new opportunities to serve children.

Ms Jones noted: I would like to have a presentation on EPSD funds at a full Board meeting, because they are so important. Ms. Ruffin replied: I would be glad to arrange a presentation of Children's Services. We have some exciting collaborative projects going on.

Ms. Ruffin continued: With regard to senior services, we have teams that go out and make visits and do evaluations and screenings. If someone has Alzheimer's, mental health refers that to another agency. We've published a brochure on our geriatric services. We try to make them extremely accessible. Our psychiatrists will go out and do home visits. Alzheimer's is not considered part of mental health. There is the Family Survival Project, now call the Family Caregiver Alliance, which has been very successful and is being replicated around the state. The State has also funded Alzheimer's assessment centers at Stanford and U.C. Davis and another at Mt. Zion Hospital.

Ms. Rossman commented: One of the things I find very frustrating is that individuals and families are suffering, because an individual does not want to go to a locked facility, who needs it, but there is nothing we can do.

Ms. Ruffin responded: You're right. Organic impairment is not considered under mental health funds, just as substance abuse is not covered. We have lots of people with dual diagnosis. But if the conservator states only organic impairment or substance abuse issues or developmental disabilities, but no mental health issues, then those cases won't be taken in court. The State is looking at introducing a new conservatorship for organically impaired people. But this has been in development for many years now.

Within the Division of Mental Health Services, we have a family support program at various clinics, serving the range from grandparents raising grandchildren to parents of adults with mental illness.

With regard to diversity at DMS, we will prepare a report for you. We do an annual report, but we can do a mid-year update.

With regard to three new hires for administrative positions:
1) We've hired Tom Mesa, who is Mexican American, as the new Director of Geriatric Services. He has been working in geriatric services.

2) I'm delighted to say we've hired Collins Munns as the new Director for the System of Care. His is an African American social worker from San Diego who has worked in the mental health system there for 24 years. He has been a Regional Director, and for the last year and a half has been the Assistant Director. Norma Block was on the panel. Ms. Block noted: Mr. Munns interviewed very well. He was very knowledgeable and very personable.

3) We are in the process of hiring a new Medical Director. The Clinical Restructuring Task Force recommended that we have a full-time Medical Director, and we have created that position. We had 6 applicants. Two people have been recommended as finalists. Both are white males who are very highly qualified.

With regard to the issue of suicides, I can't share clinical information, but I can tell you the process we follow when a critical incident occurs. When there is an incident, an administrator is notified by phone, and this is followed up with a written report which is reviewed by the reporter's supervisor. In the case of a death, there is a second meeting, including everyone involved in the incident. The person's treatment history is reviewed, an analysis is made of how the death could be prevented, and this is all done in the context of our quality management structure and under the rules that apply to quality management.

Here in mental health we have an analysis we do quarterly on all incidents and what trends are taking place and what action we need to take in response to those trends. We are talking with the City Attorney's office to find out what we are allowed to do in terms of a joint mental health analysis with San Francis General Hospital.

We have a Quality Management Committee in DMS which helps the administration identify quality issues. Both Toye and Mickey are on that Committee.

With regard to State funds for dual Diagnosis, we wrote a grant for some State funds. However the courier service we hired to deliver the grant failed to get it to Sacramento in time, so our grant was disqualified. We are pursuing redress through the courier company.

We are piloting a consumer satisfaction survey in City clinics. This is essentially a report card on the programs. The ratings will be included with the program reviews. For example, at CSP there were 49 clients surveyed and an 87% satisfaction rate. The area clients had the most problems with were in response to the following two questions: 1)Have the important people in your life been involved in your treatment to the right degree? 2) Do you receive enough assistance in your life?

Dr. Moses: I want to say I'm really happy to see you've gone out of your way to recruit minorities. Ms. Ruffin replied: Thank you. Another thing I'm proud of is that we've gone out of our way to do consumer hiring. Ms. Traveler added: My sister was hired at the new Mental Health Rehabilitation Facility. One of the things needed is more follow

up. Ms. Jones added: We should be doing job coaching. It's a wonderful idea to be hiring consumers for the Bed Committee. What about parents being included on the placement committee for children. Ms. Ruffin responded: I will check into that.

VI. MHB COMMITTEE REPORTS

Executive Committee

Ms. Block suggested changing the meeting time of the Board meeting to 6:30 p.m. since so many Board members start work early in the morning and a 7 o'clock meeting makes a long day.

RESOLUTION (MHB-97-04): Be it resolved that the Mental Health Board hold its meetings on the second Wednesday of the month, starting at 6:30 p.m. and continuing until about 8:30 p.m. (Passed)

RESOLUTION (MHB-97-05): Be it resolved that the Mental Health Board send a letter to Supervisor Leland Yee stating the Board's support for the total repeal of the City's Site Approval Ordinance (San Francisco Administrative Code Section 15.7) and urging his support for total repeal of the Ordinance. (Passed)

Ms. Ruffin noted that DMS is continuing to meet with neighbors in opposition to the move of the South of Market Mental Health Clinic to Harrison Street. She reported: We just had a relatively good meeting. We are working on mitigation measures, such as an additional police bike patrol during the day. Also we would invite the neighbors to an open house at the Clinic. We are also talking about moving some additional number of our senior clients to the South of Market Center for their therapy. Overall the conversations with seniors are going well, it's only a minority who are very vocal in opposition.

Children's Committee

Ms. Jones reported: We're taking a serious look at the Transition Services, ages 14-26. It's a crisis when children turn 18 and they haven't graduated from high school. We have to have programs geared to the needs of young people, especially for the teenage girls.

Public Relations Committee

Ms. Leib reported that preparation is well underway for the exhibit "Art on the Front Lines of Healing," which will open at City Hall on May 9th. Supervisor Bierman noted: We like having these displays. There's one there now from Central City Hospitality House.

Program and Services Committee

No report.

Consumer/Family Member Task Force

Mr. Leoni reported: At our upcoming meeting we will be looking at the preliminary draft of new proposals for the system of care under managed care.

Provider Advocacy Group
Report was made earlier in the evening.

Community Advisory Board
Mr. Dias reported: There was an update on psychosocial medicine by Dr. Susan Scheidt. Mr. Shipley added: SFGH has put into place a division of psychosocial medicine, to work with people who have medical problems as well as mental illness. There was also a report on the PARC training which is being implemented throughout SFGH to help staff be able to respond to people who are approaching a volatile situation and help talk them down instead of putting them in restraints. By this time next year all SFGH staff should be training in this method. The Smoking Task Force is looking at the issue of consumer smoking, since some people use smoking to help calm down and it does work for them. The Consumer Guidance Committee is being re instituted.

Quality Policy Committee
Mr. Shipley reported: A new Quality Policy Council is being formed, which will be one step below Jo Ruffin, and will be made up of DMS administrators as well as representatives from services and consumers and Patients Rights staff. We are currently restructuring and want to be able to link all services across the board so people don't fall through the cracks.

VI. PUBLIC COMMENT PERIOD
Comments were made by Mr. Adamek and Mr. Wise. Mr. Kalman brought up the issue of programs for the mentally ill under the Recreation and Park Department. Ms. Leib and Ms. Jones responded that it was time to follow up on a prior meeting the Children's Committee had with the Recreation and Park Department on that issue. Ms. Kilpatrick introduced herself as a new staff member in charge of adult services Westside. Mr. Word introduced himself as a researcher who was formerly on the Board of Westside and is now at the California Institute of Integral Studies.

VII. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:56 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
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MEETING OF THE FULL BOARD
Wednesday, March 12, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.—Please note new meeting time!!

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AGENDA

10 min. **I. CALL TO ORDER, INTRODUCTIONS**

10 min. **II. CONSENT CALENDAR**
- Approval of February Minutes

15 min. **III. VISITING NURSES & HOSPICE WORKERS (VHN)**
Short presentation, request for MHB support (Attachment A)

20 min. **IV. AMENDMENT OF BYLAWS—Terms of Office**
ACTION, from Executive Committee (See Attachment B)

20 min. **V. CONTINUED DISCUSSION OF COMMITTEES**

15 min. **VI. REPORT OF THE DEPUTY DIRECTOR**

20 min. **VII. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's Committee
- Public Relations Committee
- Program and Services Committee
- Consumer/Family Member Task Force
- SFGH Community Advisory Board
- MHB Representatives to DMS, Other Committees

10 min. **VIII. PUBLIC COMMENT**
Members of the public may have 3 minutes each to comment on items within the MHB's purview

IX. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

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1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The wheelchair entrance to 1380 Howard is on Grace Street, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Street off Howard.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:30 through the end of the Mental Health Board meeting, to let people into the building.

DPH

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ADOPTED MINUTES

Wednesday, March 12, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Norma Block (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Lois A. Jones; Maria Leib; Toye Moses, Ph.D., M.P.H.; Alex Rossman, M.S.W.; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Anita Burton; Peggy Gilleran, J.D.; Paula Wilson.

BOARD MEMBERS ABSENT: none

ADJUNCT BOARD MEMBERS PRESENT: none

OTHERS PRESENT: Linda Wang (DMS); Collins R. Munns (DMS); Mike Wise (Consumer; Residential Care Task Force); Mrs. Lillian Wise (Family Member); Mark Adamek (Spiritmenders, Community Advisory Board); Emerick Kalman (Family Member); Lorraine Killpack, Ph.D.; (Westside Community Mental Health Center); Ernie Silva (St. Luke's); Mary Sue Planck (MHB Staff); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Ms. Block, Chair, at the new meeting time of 6:30 p.m. Ms. Block introduced two new Board members: April Martin Chartrand who was appointed by Barbara Kaufman, President of the Board of Supervisors; and Sylvia Shue, Ed.D., who was appointed by Supervisor Amos Brown. Ms. Wang introduced Collins Munns as the new Associate Director for the System of Care for DMS. She noted that he was a social worker by training and had had 24 years experience with the San Diego County Mental Health System.

Ms. Block then announced a special item of business regarding the MHB appointment of a representative to the DMS Leadership Work Group. She said that two Board members wanted to be appointed, that she had appointed one of them, Maria Leib, but that she felt that the process had not been done right. She said that mistakes were made on all sides, and she offered her apology for the process going wrong. She said she was rescinding her initial decision and starting the process over. She said that both Lois Jones and Maria Leib, who would like to be appointed to the position, were excellent

choices and the only fair way she saw to make the decision between the two would be to toss a coin.

Ms. Jones replied that she would decline to participate in the process. She criticized the process of the initial decision, and noted that she was still upset about what had taken place, and felt that she had not been treated fairly. She said that the solution she had decided upon would be to go to the Leadership Work Group as an individual participant, and that Ms. Leib could go as the MHB appointee.

Ms. Block then agreed to appoint Ms. Leib. Ms. Rossman noted that the process of appointments needed to be improved for the future, to make it something less personal and more of a whole Board issue. Ms. Block agreed that the process needed to be improved. She said that she had already decided that anyone who wanted an appointment had to communicate their interest in the appointment directly with the Chair and that it could not be communicated second hand. Ms. Chartrand added that the request should be put in writing. Ms. Block then asked for a resolution.

> **RESOLUTION (MHB-97-06): Be it resolved that: 1) any member of the Mental Health Board wishing to be appointed to a particular position must send a written request to the Chair of the Board and the Executive Committee, in order to be considered for the position, and 2) that following the decision, the Chair will communicate the results directly to every one of the applicants for the position. (Passed)**

Dr. Moses then asked about the process for deciding between applicants when there were two applicants for the same position. Ms. Rossman then read the applicable section from the Bylaws of the Mental Health Board as follows:

> "The Chair and the Executive Committee shall appoint the Chairs of MHB Committees and any Board liaisons to other groups, organizations, task forces or committees." (Article IX - Committees)

Dr. Moses then asked how this applied to the new policy. Ms. Planck said that the Executive Committee would discuss the appointment together. Ms. Rossman said she thought that in notifying people, it wouldn't be necessary to explain the reasons for picking one person rather than another.

II. CONSENT CALENDAR

Ms. Jones asked for the following change in the minutes: On page four, the second to last paragraph, the following: "Ms. Ruffin responded: We *have trained* all Children's Services staff on reapplying for SSI," should be changed to read: "Ms. Ruffin responded: We *are planning to train* all Children's Services staff on reapplying for SSI."

RESOLUTION (MHB-97-07): Be it resolved that the minutes of the Mental Health Board meeting of February 12, 1997, be approved with the correction noted above. (Passed)

III. VISITING NURSES AND HOSPICE WORKERS

Ms. Block introduced Liz Hartman from VNH, Visiting Nurses and Hospice Workers, as follows: You may be wondering how this relates to mental health. VNH wants to unionize and wants to join the union which covers mental health staff.

Liz Hartman introduced herself as a hospice social worker, and made a presentation as follows: We began a campaign to unionize and met with a lot of obstacles. We decided to take the issue to the community. We feel the services we provide are very valuable, but we don't feel we can provide quality care under the current conditions. I was not originally pro-union, but I was very concerned about the quality of care, and so now I'm supporting unionization.

In both home health and in healthcare in general, the trend is toward managed care. Services are being cut back and cut back. There is pressure to discharge patients quickly and pressure not to spend time with patients. So we find ourselves in a situation where we can't provide quality care unless we put in unpaid hours or even days. This is a scary trend.

We went to the community because we didn't know what else to do. We'd like to ask for your support and endorsement.

I face a battle when I get someone with a dual diagnosis, with both mental health and physical issues. Under managed care, I'm ending up having to do crisis intervention, then I have to go out to the community to find continuing care for my patient, and then I have to battle the insurance companies to get the care authorized.

I know managed care was originally started to cut costs, and justifiably so, but it seems to have gone to an extreme. A lot of people are going to end up in the hospital again, and of course, that's going to cost more not less.

We simply can't work under current conditions and get the work done.

Ms. Traveler: I hear what you're saying. My sister is a mental health client and has had physical illnesses, and it's true that the doctors don't want to collaborate. What is it that VNH wants?

Ms. Hartman: We want a voice in our field. They've hired a union-busting law firm. We're working out there in the field and we want to be listened to and trusted when we talk about what's needed. Decisions have been made without our input. There are other issues, too, like unpaid overtime and labor violations. I am not paid overtime, but I am expected to put in the time to finish the job, and at the same time there are no benefits.

Ms. Traveler: This is a big problem not just in California. This is escalating and union busting is escalating.

Ms. Hartman: We'd like to be able to list you as an endoser, and ask that you send a letter of support.

Dr. Shue: I've heard of a physcian's group back East trying to unionize. Ms. Hartman: I've heard about that, too. A lot of health care providers are feeling frustrated and especially when dealing with the health management companies. I don't want to single out VNH, because the problems are industry-wide.

Our nurses are expected to see 6 patients a day, and that doesn't take into account the travel time and the tremendous amount of paper work involved. You have to document every phone call and consultation.

Ms. Rossman: Have you had anyone die due to lack of services? Ms. Hartman: Not to my knowledge, but these patients are accidents waiting to happen. Ms. Rossman: A lot of times systems wait till someone dies to make changes. Have you started documenting recidivism? Ms. Hartman: Not that I know of, but I know of a lot of cases personally. Ms. Rossman: I'd recommend documenting that. Ms. Hartman: You're right; they want to see facts and figures and documentation.

Dr. Beauford: To your knowledge what percent of VNH workers are against unionizing? Ms. Hartman: I believe 80-90% are in favor of unionizing. You'll always have some people who are opposed to the union.

RESOLUTION (MHB-97-08): Be it resolved that the Mental Health Board of San Francisco endorse the efforts of Visiting Nurses and Hospice Workers and send a letter to Sutter/CHS and the California Pacific Medical Center to notify them of this endorsement. (Passed)

IV. AMENDMENT OF BYLAWS—Terms of Office

Ms. Block referred to Attachment B and explained that the Executive Committee is recommending that the terms of officers be changed from one year to two years, and that if the proposal is approved, the election next February would be the first time that the two year term would take effect—it would not apply to current officers.

Ms. Jones noted the following: I kind of take exception to this amendment. I agreed to send this on, but I have some concerns. I called around this afternoon to other Boards and Commission and no one does this. I voted to send it to the full Board, but did not vote to recommend it.

Ms. Leib noted that the Mental Health Board could do things differently if it so chooses, and said that it takes a lot of time to get projects going, that one year is not enough time.

RESOLUTION (MHB-97-09): Be it resolved that the Mental Health Board change Article V, Section 2, of the Bylaws to read: "2. They shall be elected at the February meeting of the MHB in even-numbered years, and shall serve a term of two years, or until their successors are elected."; and change Article VI, Section 1, to read: "A Nominating Committee shall be appointed by the Executive Committee by the last meeting of each odd-numbered year and shall consist of no fewer than three (3) members of the MHB." (Passed)

V. CONTINUED DISCUSSION OF COMMITTEES

Ms. Block reported as follows: After all the survey forms came in and after all our discussion, we're right back where we started with the same committee structure, which is fine if this is what people want.

VI. REPORT OF THE DEPUTY DIRECTOR

Ms. Wang reported for Jo Ruffin as follows: One of the questions the MHB asked me to respond to was if we had instituted a policy of providing atypical neuroleptics for indigent clients. We have done that. And the current DMS Pharmacy Newsletter which I have copies of for you, announces the process for requesting an authorization for an indigent client who a doctor thinks needs an atypical neuroleptic. Lewis Eng, the DMS Pharmacist, confirms that the request is similar to the MediCal authorization. The form goes to the DMS Pharmacy for review and, if appropriate, it's approved.

With regard to the Teen Hotline, it's being sponsored by Coleman Advocates and our mental health providers are on their referral list.

Ms. Jones: How do teens know about this? Ms. Wang: I anticipate that Coleman will publicize it. Ms. Jones: How will teens in the DMS system know about it? Ms. Wang: When we get the information, we'll distribute it to our programs. Ms. Planck said that she would call Coleman to find out if the line is operating yet.

Ms. Wang continued: With regard to the Foster Care Proposal which was sent to the Mayor's Office, we haven't heard anything so far. Sai-Ling said that kind of request would probably be put on hold until it's known what kind of federal funds will be made available to the state, and then the request for the foster care funding would be made to the state.

With regard to welfare reform, Jo reported last time on training our staff. We've been talking about finding private providers who can do re-assessments to whom we could refer families. We've also been doing joint planning with other agencies. There are about 140 DMS clients in Children's Services who are in danger of losing their SSI.

Dr. Moses: If the foster care proposal doesn't go through is there a back up plan to keep the Foster Care Program going? Ms. Wang: Sai-Ling has identified another possible source of funding.

Ms. Wang continued: Sue Bierman's proposal to repeal the Site Approval Ordinance was heard at her Health, Family, and Environment Committee on February 27th. The hearing will be continued on March 27. We're expecting the Committee members to vote for repeal, although there is some opposition to repeal.

Monday night Monique Zmuda from DPH and I attended the Small Business Advisory Commission. They voted unanimously in opposition to the repeal of the Site Approval Ordinance. They will be sending their position over to the Board of Supervisors. The Commission wanted neighborhoods to continue to have a say about what comes into the neighborhood. Their position was that if this Ordinance is discriminatory, then all programs should be included under it. They said if a business is required to put up a sign, why shouldn't a mental health program be required.

Ms. Leib: Sue Bierman said she had received some of the nastiest phone calls she's ever received in opposition to this repeal, which is saying something. Mr. Shipley: Bill Hirsh wrote a letter to the editor which the *Chronicle* published and it was excellent. Ms Planck: He highlight the fact that neighbors can have a say about what moves into the neighborhood, but not about who. That's where rights get trampled. Dr. Moses: We need to have a crowd show up at the hearing. Two weeks ago people from Bayview/Hunters Point opposed a liquor license being granted and we went to the hearing in numbers and got 3 votes.

Ms. Wang: The Rehabilitation Facility now has over 100 clients and we expect that by the end of March all beds will be filled by people transferring back from out of county or people coming in directly from acute services. The first phase of start up has been focused on bringing people back from the IMD's who have rehabilitation potential should be given the opportunity for rehabilitation, and people who had been in the IMD's many months should have the opportunity to be closer to families.

We are still planning to eliminate 80 IMD beds by the end of the fiscal year. The funding will be shifter to the SPR programs. A number of clients in the IMD's and the Rehabilitation Facility are eligible for applying to the SPR's.

Dr. Moses: Do you know the geographical location and ethnicity of the people entering the Rehabilitation Facility. Ms. Wang: The geographical location is hard to know, since many of the client addresses are outdated, and many have no address, or their address is the IMD. I can get the ethnic breakdown for you.

Dr. Moses: I would like to see if our people from Bayview/Hunters Point are taking advantage of this new facility. Ms. Planck: I talked with Mary Louise Fleming, and she is willing to come to the Program and Services Committee and she might be able to answer that.

Ms. Traveler: Is there any information on how staff of the Rehabilitation Facility are being treated, especially consumers who have been hired. Ms. Wang: That can probably be best answered by Mary Louise Fleming, but the start up time for a facility that large is a hard period. Ms. Traveler: How they are being supported is the question.

Ms. Wang: We are hoping the South of Market Clinic will move to its new location in June. We are continuing to have meetings with the South of Market housing managers and telling them about services available, especially for seniors and children. We have done our very best to reach out to organizations and people in that community.

VII. MHB COMMITTEE REPORTS

Executive Committee

Ms. Block announced that John O'Brien, a former member of the Mental Health Board, passed away.

Ms. Block called attention to the DPH Good Neighbor Policy that was in the second Board packet.

Children's Committee

Ms. Jones reported: Last Friday I met with Sai-Ling, the BAR Association, and the Youth Law Center on the issue of SSI and families being cut off. The matter is urgent because two weeks ago the federal government published the regulations, specifically targeting kids with mental illness and maladaptive behavior problems. DHS is estimating that 900-1200 people in San Francisco will be targeted. DMS and the Mayor's Office, to their credit, are looking at funding advocacy.

We've also been working on the Transition Program at our Committee meetings. We've invited Ms. Wang to attend our next meeting to talk with us about developing a survey of adult programs to ask them why they don't want young people in their programs, and to see if we can take down some of the barriers. We need to design adult programs for young people from 18-26.

There is a lawyers training coming up, put on by the BAR Association, to teach people how to advocate for the children being cut off SSI. The new regulations have not taken away the functional assessment for kids, but have just moved it down the list, and are making it harder for parents to document their child's need.

Ms. Chartrand: Do you know about the BAR Association volunteer bank? The BAR has done a great job of helping women like myself who are legally disabled. I was able to hook up with one of their volunteers who was my mentor for 3 months.

Ms. Jones: We're talking with them about doing outreach to places where these kids are. Going back to foster care, a law was just passed saying that the county where the child lives has to take care of mental health services for the child, which could become a barrier for kids getting services.

Public Relations Committee
Ms. Leib reported: "Art on the Front Lines of Healing" will be opening on May 9th. We like to do a reception each May, which is Mental Health Awareness Month, to increase our visibility in the community. This year we are working with the Art Commission, Art for Recovery, and the Arts and Healing Network.

Ms. Block added: Last year it was just mental health art. This year it will be more inclusive, covering a wide range of disabilities and illnesses. Ms. Planck: We want to expand the audience beyond the mental health community. Mr. Snowdon: Ms. Chartrand is one of the featured artists who will be showing her work in the exhibit. Ms. Chartrand: I'm also working on the committee to put more arts into the mental health system.

Program and Services Committee
Dr. Moses reported: The Program and Services Committee is the best! I am the acting Chair. The Committee arranges for program reviews and we talk about client issues. We also talk about programs like the Mobile Crisis Unit, which is unusual and difficult to monitor. But we are working on a way to do that.

We've talked about the use of acupuncture. When I reviewed Bayview/Hunters Point last year, I found it to be an excellent program, I was very impressed. I found out that they use acupuncture as part of their treatment program. It was very effective and cost-effective. Ms. Rossman asked if the Committee would also consider herbs and other Eastern modalities. Dr. Moses: We're open for suggestions.

Dr. Moses: In advance of doing program reviews this year, we'll be two training sessions for people who will be going out to do the reviews. We have lots of questions about the Rehabilitation Facility, and plan to meet with Mary Louise Fleming, and then bring recommendations back to the Board.

Mr. Shipley: On the issue of acupuncture, this is a very important issue across the boards, including with HIV and substance abuse services. It's used in jails for people under stress. Why not use it in mental health programs?

I went to the Mobile Crisis Steering Committee meeting. I brought up questions about the recent suicide, and if Mobile Crisis could do anything about people who fall through the cracks. I'm concerned about people who go into the hospital and in the meantime lose their SRO room. Is there some way to prevent this so they don't become homeless?

Ms. Wang: We actually have an acupuncturist on staff at the Chinatown/Northbeach Clinic. We only have one in the system, but the service has been provided for the past ten years. Originally it was a demonstration project, but now it's in the City budget.

The acupuncturist is available to clients from other programs in the system. Dr. Moses: The clients at BVHP were so happy about their acupuncture, and relaxed by it.

Consumer/Family Member Task Force
Mr. Shipley reported: I'm one of the Executive Committee members. At the last meeting we discussed the recent article on the suicide and what we could do as consumers and family members. Since it's still under investigation there's not much we can do right now. We've also been discussing the System of Care changes and will continuing following that issue.

Community Advisory Board
Mr. Shipley reported: We had a very short meeting, since it was also a farewell party to honor Ralph Jacobson who is going off the Board since his term of service has come to an end.

Quality Policy Committee
No report.

Family Mosaic Advisory Committee
Dr. Moses: The Committee is dying, so we're trying to bring it back to life. The attendance has been low. Ms. Leib added: There was lots of enthusiasm at first, but now it's dying down.

VIII. PUBLIC COMMENT PERIOD
Mr. Wise announced the managed care update for consumers and family members on March 22nd.

Mr. Kalman suggested that the MHB should have more outreach and should be including other support groups, such as the Alliance for the Mentally Ill. He recommended getting all the legal codes and regulations regarding the Site Approval Ordinance. Ms. Planck replied that that had been researched and written up by Protection and Advocacy and that she could send him a copy.

IX. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:32 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3567

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MEETING OF THE FULL BOARD

Wednesday, April 9, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.—Please note new meeting time!!

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AGENDA:

10 min. **I. CALL TO ORDER, INTRODUCTIONS**

10 min. **II. CONSENT CALENDAR**
- Approval of March Minutes

40 min. **III. S.F. MANAGED MEDI-CAL MENTAL HEALTH CARE PLAN**
Presentation, by Nancy Presson and Louise Rogers; request for MHB endorsement (See Attachment A)

25min. **IV. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's Committee
- Program & Services Committee
- Public Relations
- Consumer/Family Member Task Force
- SFGH CAB
- DMS Committees
  - —Managed Care
  - — Leadership Work Group
  - — Quality Improvement
  - — Other Committees, Task Forces

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25 min. **V. REPORT OF DEPUTY DIRECTOR**

10 min. **VI. PUBLIC COMMENT**

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

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SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:30 through the end of the Mental Health Board meeting, to let people into the building.

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SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES

Wednesday, April 9, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Norma Block (Chair); Supervisor Sue Bierman; Anita Burton; April Martin Chartrand; Darwin Dias; Peggy Gilleran, J.D.; Maria Leib; M.P.H.; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler.

BOARD MEMBERS ON LEAVE: Jim E. Beauford, Ph.D.; Toye Moses, Ph.D.; Alex Rossman, M.S.W.; Paula Wilson.

BOARD MEMBERS ABSENT: Lois A. Jones.

ADJUNCT BOARD MEMBERS PRESENT: none

OTHERS PRESENT: Jo Ruffin (DMS); Collins R. Munns (DMS); Mike Wise (Consumer; Residential Care Task Force); Mrs. Lillian Wise (Family Member); Dwight D. Darkes (Consumer); David P. Smith (Consumer); Reverend "Sifu" Shessa (Consumer/Family Member Task Force); Armando Sosa (Community Advisory Board); Mark Adamek (Spiritmenders, Community Advisory Board); Emerick Kalman (Family Member); Lorraine Killpack, Ph.D.; (Westside Community Mental Health Center); Ernie Silva (St. Luke's); Mary Sue Planck (MHB Staff); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Ms. Block, Chair, at 6:30 p.m. Ms. Block welcomed Ms. Gilleran back from her leave of absence.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-10): Be it resolved that the minutes of the Mental Health Board meeting of March 12, 1997, be approved as submitted. (Passed)

III. SAN FRANCISCO MANAGED MEDI-CAL MENTAL HEALTH CARE PLAN

Ms. Presson made a presentation as follows: You've received copies of the implementation plan along with the cover memo or executive summary. We wanted to make sure you got a chance to read it in advance. I just want to remind people where

we are, and I want to thank you for your patience as we go through different versions of this document.

Three years ago we came before you to explain the State's intention to move people on MediCal into managed care and to foster competition in health services. In San Francisco there are two plans now for families:

1) The Local Initiative Plan, which is called the San Francisco Health Plan. Jo Ruffin sits on the Board of Directors of the plan, as do representatives of hospitals servicing people covered by MediCal.

2) An HMO. In San Francisco, Blue Cross won this position.

But at the same time as this was being proposed, mental health advocates and directors were worried that if mental health services were incorporated in these plans, mental health would lose the gains made over the years, programs would be watered down, and there would be a return to the medical model. These advocates won what's called a "carve out" of mental health services.

This made sense, since 75% of MediCal dollars were already going through the County Departments. The county was given the right to take over as provider or they could turn down that option and then other providers could bid for it.

There are lots of financial implications which follow from this choice. If we didn't take charge, part of our budget, the MediCal portion, would be returned to the State.

There were in those days two ways to access mental health services. There was the fee-for-service mode, which was operated by the State under Short-Doyle funding. There were two parts to the fee for service: inpatient and outpatient. The consolidation of the inpatient services took place two years ago and has been very successful.

Outpatient consolidation is scheduled for October 1997. Under the current system, psychiatrists and psychologists bill the State for a set rate for the services they provide, and there are lots of limitations on what services they can bill for.

Two years ago the City and County of San Francisco passed a resolution to take over the consolidation of services.

The options were for the consolidation to take effect in October 1997 or January 1998. We chose October. This means that by May 15, our implementation plan has to be in to the State. Therefore we appreciate you scheduling us for this meeting tonight.

We're getting a state allocation right now, but sooner or later, they will capitate us, meaning we'll be given a specific amount of money per person per month. The rate may

be different for different categories of people, such as families on TANF (Temporary Assistance for Needy Families), or people who are disabled.

This implementation plan is mandated for MediCal recipients but San Francisco has said that it will also provide the same set of services for the indigent population. Consolidation will broaden the range of who we can see. We've requested through our budget this year to be able to extend services to the indigent population.

Ms. Rogers then presented the elements of the plan as follows: The plan has to respond to State requirements, but it is written so that people at the Health Commission and Board of Supervisors can jump in and understand the issues.

The section on mission, goals, and values, reflects concerns and values lots of people have expressed about the continuity of care.

Ms. Block asked about consumer choice. Ms. Rogers replied: The State is concerned as well. On page 30, consumer choice is addressed. DMS agrees that choice is a value for consumers. DMS agrees that there will be a procedure for consumers to request a change of providers. We are working to make sure we have providers who are culturally and linguistically appropriate.

Ms. Block asked how hard it would be to switch providers. Ms. Rogers: That process is not invented yet. The problem is that we are not sure yet that we'll be able to recruit enough private providers. We're talking about increasing the provider network to include social workers and other therapists. The State will only give us the same amount of money we've had historically. We are saying that we won't cut the rate for providers. Our goal is to streamline the administrative process and pay providers within 15 days, as an incentive to providers.

Ms. Chartrand: My findings in going through the system are that I have to fill out the same paper work in two different services. There is a need for a computer database. I'm concerned that someone will give up on getting help because they can't do the paperwork.

Ms. Rogers: DPH and DMS are doing a lot of work on developing a centralized database.

The Managed Care Committee is an open committee which meets once a month to develop ideas. A couple years ago the Mental Health Director created a Leadership Work Group. She appoints members from all the different parts of the system. This group reviews all plans before they go to the MHB, the Health Commission, and the Board of Supervisors.

Page 15 begins to describe the System of Care. There are three parts to the structure.

1) Provider Network. Since consolidation requires responsibility for huge numbers of clients, we have to streamline as April says, and we have to include many more providers—from the private sector, from community agencies, from city programs. We are developing a streamlined referral system. It can't be costly because we are not getting a lot of money to administer the program. People will be authorized for a number of visits at the access point. It could be a different number for different people, but it won't be an unlimited number of visits.

Ms. Presson: Right now the decision is made if someone is eligible for treatment services or not. But under consolidation, many more people will be eligible, but for a limited number of visits. The number can be extended but only if medical necessity is present.

Ms. Rogers: The State will detail what will be covered by the mental health system and what will still get billed to the State.

Mr. Leoni: At what point will the County flesh out the definition of medical necessity? I'm concerned we could end up with a definition almost as restrictive as the target population now.

Ms. Presson: The pilot counties have been using the State definition of medical necessity as stated. But we're going to develop a provider document and a consumer manual to outline what services are provided.

Ms. Rogers: Tina Yee's office will develop a manual and make it as user-friendly as possible and provide help for consumers to understand it if necessary.

Ms. Traveler. Could you give us a visual picture of how the new system will work, starting with when a consumer walks in and begins to fill out the paper work? And who approves the number of visits.

Ms. Presson: What I'd like you to think about are 3 different kinds of services:
1) prevention, 2) emergency, and 3) planned.

Prevention services are now in the schools and clinics. We want these to continue, because they are very helpful. No authorization is needed for them.

The plan requires us to assure emergency services for all who need it, including hospitalization as needed. We just need to be notified within 24 hours that someone has come in for emergency services. That's working very successfully.

Most services are planned services. In this system planned services have to be prior approved.

We will have an 800 number answered by human beings to help people find providers. That will be a way into the system. We will be able to check for eligibility, and we will

be able to check from the computer if the person has been seen before. We'll ask the person some questions, and based on that evaluation the person will be referred to someone in the provider network. Past users of the system will be referred to the city clinic.

We are working on having access to the system by phone and also the centers people are used to walking into.

Part two of the three parts of the system is the new Single Point of Responsibility Programs. These are for high-end users and are using the Assertive Community Treatment model. The agencies selected to run the new SPR's are UCSF/SFGH, Westside, and Mission Multicultural Assertive Community Team. They provide services 7 days a week, 24 hours a day to pre-identified individuals. The Family Mosaic Project is the equivalent for the Children's Services.

This is a new way of paying for health care, and it involves risk sharing. The programs will be paid a certain amount per member per month. Their reason to take on these programs is that the SPR gives them much more flexibility in the services they can offer.

The third part of the three parts is 24-hour placement. These placements are a precious resource because they are scarce in San Francisco. We have to prioritize the resources for those who need them the most. The Bed Committee does this for adults. There is also a Geriatrics Committee, and a Children's Committee.

Access looks like it will be better under the new system. We will give current providers six months to decide if they want to become members of our plan. We assure payments for visits for that time. No one will be dropped who needs to be seeing a therapist. Six months is a very generous amount of time for providers to make their decision. We're hoping providers will decide to join and go through our credentialling process.

Dr. Shue asked about the Mobile Crisis Unit.

Ms. Presson: The Mobile Crisis services described reflect the current reality. The Child Crisis services operates 24 hours a day. The Mobile Crisis for adults is not a 24 hour service, but PES is open 24 hours, it's just not mobile.

Ms. Ruffin: The plan requires emergency services, which PES covers. The issue of Mobile Crisis is a funding issue.

Dr. Shue: It looks like you are developing a system that is supposed to be flexible, but you have layers of committees and councils and you need a single system. You need to treat people holistically. Mr. Shipley : The flow chart being developed by the QPC would be helpful to see how the system works.

Dr. Shue: I love the cultural competency, because that has been lacking.

Ms. Gilleran: Regarding the Bed Committee, there were complaints last year about people on the Bed Committee making decision without knowing the clients or talking with the people working with the clients.

Ms. Presson: There are three separate committees: The Interagency Placement Committee (for Children's Services), the Geriatric Placement Committee, and the Adult Bed Placement Committee. We have done a lot of work to develop the Bed Committee to make it easier for the referred person. I think if you went back to the services who have complained in the past, you'd hear better reports.

The Bed Committee approves the level of care. But we can't assure placement in a system of scarcity. There is now a consumer representative on the Bed Committee and also representatives of services. We worked with the Consumer Task Force to develop a form for consumers to be able to say what's important to them. If there is a question about what the client wants, the consumer staff person on the Committee goes out and talks with the consumer being referred. Ms. Gilleran: That's very satisfactory.

Ms. Burton asked about outcomes. Ms. Presson replied: The Quality Policy Committee is overseeing the Quality Management Plan. We are very interested in moving to client satisfaction surveys and outcomes as opposed to auditing programs by documents and charts. We are piloting an instrument now which may be used statewide.

Ms. Burton asked about prevention programs in the schools. Ms. Presson: We have contracts with schools and childcare center. Mental health staff is available for consultations and mental health staff go out into the classrooms to work right along with the teachers.

Ms. Traveler: I don't see the union listed under the interagency agreements. Ms. Ruffin: The union relationship is the prerogative of the Human Resources component of the city. Negotiations are not handled by the Departments.

Ms. Traveler: I'm concerned about when there's a client hired by DMS to work as part of a program and that client has a problem, who do they go to. Ms. Ruffin: If they are employed by us, they have the right to join a union, if they are in an appropriate class. All staff are oriented to this. I don't know if consumer staff are a represented class, but there's always a process for handling problems whether the staff person is represented by the union or not.

Mr. Shipley: One concern is under managed care, vocational training is going to be a very important part of this plan. So far I only see CVE listed and they only have 4 distinct employment tracks, and only offer one-year transition jobs. My concern is that their budget and resources are currently getting strained and under this plan, there will be more referrals to them, I'm concerned about whether they can handle it.

I'm also concern about housing. SRO's don't count as housing for mental health clients; they need supportive housing. We had a 5-year housing plan. People are going into the MHRF and their housing is gone when they come back out.

Ms. Ruffin: Managed care doesn't cover that or address it. But we have tried to address it through a whole variety of HUD grants and residential services, such as Progress Foundation opening a new facility this week and a new hotel being opened next week. We are working to increase co-op housing. I agree with you completely, housing is part of everything we do, and it's a problem that the managed care plan does not cover housing.

Mr. Shipley: I'm concerned about residency. If someone moves into San Francisco and has been here less than 3 months, and they get sick and the responsibility for payment is elsewhere, but they are going to be denied services, what can be done?

Ms. Planck: This issue just came to the MHB today. We are hoping the CTF and the Executive Committee can develop some recommendations for Jo.

Ms. Rogers: The State is giving us a set amount of money to run our plan. One assumption is that if we offer prevention and early intervention services, we won't need the higher end services as much. These kinds of services are easier to provide if there is an identifiable client base as opposed to if people are here for a day and then need residential services.

Ms. Ruffin: The action that is needed from the Board on this plan is a letter stating that you have reviewed the plan. We expect the development of our system will be ongoing and changing. The State keeps giving us new things that have to go into it. You can give us feedback in writing at any time. The public can have input in two ways. 1) The monthly Managed Care Planning Committee is an open committee. 2) You can give us your number and one of us will call you for your concerns.

Ms. Traveler: Are most counties doing the implementation starting October 1? I feel like we are rushing and pushing. Ms. Planck: What are the consequences of starting on January 1st? Ms. Presson: We had hoped to start on October 1st. We think we will have better access to the system and offer more services and do a better job under the new plan. The Provider and Consumer manuals have to be submitted to the state by September 1st. That's why we're saying we'd be glad to do another meeting with you before then and those manuals will address the issues that you're raising.

Ms. Ruffin: The State requires only that the MHB review the plan. I am happy to come back and meet with a subcommittee if you like. We have a tight time frame. This process got jammed up because the State gave us very short lead-time. The staff has been working day and night on this plan and it still has to go to the Health Commission and the Board of Supervisors. Something may change at the Health Commission. There

may be further discussion. I've been in Sacramento all day and the State is adding to the requirements as we speak.

Ms. Planck: Jo, Nancy, and Louise are as good as their word. You can call them up.

Ms. Presson: Our planning process is to seek as much input from the community as we can—from the Mental Health Board, the Consumer Task Force, and from providers. We do that through a series of meetings. We have been talking about the elements of this plan for a long time.

Supervisor Bierman: I do think the language in the resolution is all right, but maybe language should be made stronger, such as "the details of the plan will be worked on. We and the public will look at future drafts for more public input."

Ms. Burton: We're here to serve the public and I think it's important for them to have time to comment on something as important and emotional as this plan.

Ms. Shessa: This is not a review; it's not an adequate detailed review. Consumer input is lacking. You talked about the handbook—that's providers talking down to consumers. That's not grassroots input. The gaping hole in this is the lack of consumer input. Consumers are past begging, now we're going to have to demand.

Mr. Adamek: I'm a mental health consumer. I took a look at the plan, glanced through it. It's a complex instrument. Much more input is needed from those who will be affected by it.

Supervisor Bierman. Perhaps the language could be that the MHB has "reviewed the plan, and have reserved support until future plans are developed."

Ms. Ruffin: Whatever is sent to the State will be given to the MHB to review first. This can be an ongoing process and we'll come back anytime and meet with you anytime you like.

Ms. Block: I'd like to suggest a meeting when we could discuss this plan before May 15th. This could be the one item on the agenda. It could be a meeting where the public has the majority of participation time. Ms. Ruffin: We'd be glad to co-host it with you. Ms. Block: Members of the public are invited to leave their name and address with us, so we can notify you of the meeting.

Mr. Wise: I think this discussion is tremendously unfair to Jo and Nancy and Louise. People are saying you haven't come to us over the years, but there have been many nights of discussion. Nancy has been to so many meetings. It's tremendously unfair to say we haven't been on board for this process. Maybe some people feel they have not had the influence they wanted—that's an individual opinion. You have your deadlines and I respect you for including us in the process.

Mr. Leoni: The issue is not that you guys haven't involved us. The frustration comes from the State deadline. Some counties are asking for an extension.

Ms. Block: A meeting will be set up which will deal only with managed care, not in a lecture format, but more of a public forum.

RESOLUTION (MHB-97-11): Be it resolved that the Mental Health Board of San Francisco notify in writing the Department of Mental Health of the State of California that it has reviewed at its meeting on April 9, 1997, the current draft as of that date of the Managed Care Implementation Plan of the San Francisco Mental Health Plan which was developed by the San Francisco Division of Mental Health Services; and be it further resolved that the Mental Health Board will notify the State Department of Mental Health that it has agreed to continue to work with the San Francisco Division of Mental Health Services to review all further development of the Implementation Plan. (Passed)

IV. MHB COMMITTEE REPORTS

Executive Committee

Ms. Block: I want to acknowledge Supervisor Bierman and thank her for her leadership in the repeal of the Site Approval Ordinance. That ordinance has been a source of contention for mental health consumers. It's been a terrible ordeal.

Supervisor Bierman: You did the work. I appreciate you. You really got the job done.

Public Relations Committee

Ms. Leib gave an update on the exhibit "Art on the Front Lines of Healing" which will be opening on May 9th.

V. REPORT OF THE DEPUTY DIRECTOR

Ms. Ruffin reported: Our intention is to expand and improve care through the new Managed Care Implementation Plan. Our feelings are not hurt by your comments. We really value them and will continue to ask you for input.

I think Supervisor Bierman is personally the most courageous Supervisor in many years. The Site Approval Ordinance has been an absolute nightmare for us for the last ten years. People on your Board and on the R-Team deserve a round of applause for all your work and testifying and calling.

I'd also like to acknowledge Dr. Sandra Hernández and DPH Board Liaison Anne Kronenberg, for personally approaching each Board member to create an unprecedented unanimous vote for repeal.

Supervisor Bierman: After all my years on the Planning Commission, this was one of the most painful issues. My aide June Gutfleisch was really the guiding spirit for this effort. Ms. Planck: Yes, she was really passionate about this issue.

Ms. Block: We'll send out thank you letters to Dr. Hernández, Ms. Kronenberg, and Ms. Gutfleisch. Also Bill Hirsh of the MHA for his extensive lobbying for repeal.

Supervisor Bierman: In the whole struggle over the move of the South of Market Clinic and on this issue of the repeal of Section 15.7, Rev. Supervisor Amos Brown was really there with us, he was just wonderful.

VI. PUBLIC COMMENT PERIOD

Mr. Wise: I know that issues of concern about the Office of Self Help and the STEP Project have come to Jo and was looking forward to her commenting on these issues.

Ms. Ruffin: There have been questions raised. We are reviewing them. I brought materials tonight, and I'll put a response in writing. But for now, briefly, our position is that the Office of Self Help is providing services. There has been a problem with the site which is not their fault. The Office is now operating out of Room 708 at 1095 Market Street. There has been flooding at the site at 165 Fell Street. The office is not paying rent there now. The landlord and the City both have lots of money invested. The lawyers have been meeting to work out the problems. In the meantime the Office is somewhat limited in their services.

Mr. Kalman: How is the budget going along? I see only $50,000 in maintenance for mental health facilities. Ms. Ruffin: That is a special fund under the Mayor's Office; it's an additional allocation, not all the maintenance in our budgets.

Mr. Kalman then asked about the move of emergency services. Ms. Ruffin: There has been a year and a half of work to move Emergency Medical Services to the Fire Department, including ambulance services. I talked with Mitch Katz of DPH. There will be no change in the types of services given mental health clients. The same staff is being transferred, so the expertise will go with them to the Fire Department.

Mr. Adamek asked about the Office of Consumer Affairs and Proposition 209.

Ms. Ruffin: The Office of Consumer Affairs is in the budget for next year, and so far no one has taken it out. With regard to proposition 209, there is no change in the Department of Public Health or DMS from our position that all programs will be culturally representative, including the Board of Directors and staff of programs.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:46 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3567

SPECIAL
MEETING OF THE FULL BOARD

Wednesday, April 30, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

There will be only one Agenda item :

- **REVIEW OF SAN FRANCISCO MENTAL HEALTH MANAGED CARE IMPLEMENTATION PLAN:**
  - A. CONTINUED BOARD DISCUSSION
  - B. PUBLIC COMMENT PERIOD
  - C. POSSIBLE BOARD ACTION

It is hoped that concerned individuals will have read the document and be prepared to discuss its contents. There will be copies available, for those who wish to see them, of the Exhibits and MOU's (*Memoranda of Understanding* with other Departments, Programs, Groups), which will be part of the complete Plan as it is submitted to the Health Commission. If you need a copy of the document, it is available at 1380 Howard Street at the 5th floor reception desk.

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The wheelchair entrance to 1380 Howard is on Grace Street, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Street off Howard.

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SAN FRANCISCO MENTAL HEALTH BOARD

April 30, 1997

The Minutes of this meeting are missing.

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SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3567

MEETING OF THE FULL BOARD

Wednesday, May 14, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.—Please note new meeting time!!

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AGENDA:

10 min. **I. CALL TO ORDER, INTRODUCTIONS**

10 min. **II. CONSENT CALENDAR**
- Approval of April Minutes (2 sets)
- Letter on Housing for Mentally Ill - See Attachment A

40 min. **III. SPECIAL PRESENTATION: Youth Talk Line** - Jason Singer, of C.H.A.L.K. will be present to talk about this program, which is about to get started. The MHB advocated for there to be a youth phone talk line.

25min. **IV. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's Committee
- Program & Services Committee
- Public Relations
- Consumer/Family Member Task Force
- SFGH CAB
- DMS Committees

25 min. **V. VISIT WITH SUPERVISOR AMOS BROWN:** Supervisor Brown will be coming from another meeting, so if he arrives in the middle of Committee Reports, we will interrupt the Reports as a courtesy to him.

10 min. **VI. REPORT OF THE DEPUTY DIRECTOR**

VII. PUBLIC COMMENT PERIOD: Members of the Public will have up to 3 minutes to comment on any issue within the MHB's purview, except for issues on which they have already commented.

VIII. ADJOURNMENT

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DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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(415) 255-3474
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UNADOPTED MINUTES

Wednesday, May 14, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Norma Block (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Peggy Gilleran, J.D.; Maria Leib; Toye Moses, Ph.D., M.P.H.; Alex Rossman, M.S.W.; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler.

BOARD MEMBERS ON LEAVE: Anita Burton; Lois A. Jones; Paula Wilson.

BOARD MEMBERS ABSENT: Supervisor Sue Bierman;

ADJUNCT BOARD MEMBERS PRESENT: none

OTHERS PRESENT: Collins R. Munns (DMS); Mike Wise (Consumer; Residential Care Task Force); Dwight D. Darkes (Consumer); Robert A. Schreiber (Swords to Plowshares); David P. Smith (Consumer); Gil Canedo (Consumer); Mark Adamek (Spiritmenders, Community Advisory Board); Emerick Kalman (Family Member); Lorraine Killpack, Ph.D.; (Westside Community Mental Health Center); Ernie Silva (St. Luke's); Mary Sue Planck (MHB Staff); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Ms. Block, Chair, at 6:31 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-12): Be it resolved that the minutes of the Mental Health Board meeting of April 9, 1997, be approved as submitted. (Passed)

RESOLUTION (MHB-97-13): Be it resolved that the Mental Health Board support the position taken by the Mayor and the Board of Supervisors that existing housing in the Presidio should be preserved and rented to low income and very-low income San Francisco, and be it further resolved that the Mental Health Board request that some of that affordable housing be reserved for people with mental illness. (Passed)

III. SPECIAL PRESENTATION: Youth Talk Line

Ms. Block: We have Jason Singer here from CHALK. The MHB has had some participation in the planning meetings for the teen line. I work on a parental crisis line and I know how effective these lines can be.

Mr. Singer: I want to thank Norma, Mary Sue, and all of you for the opportunity to make this presentation. Let me first introduce myself. I'm the Co-director of CHALK. The other Co-Director is David Glickman. Our charter is to get the community involved in the lives of kids. CHALK is relatively new. It was founded about a year ago. It's been a blistering big year. We began working with the Mayor's Office of Children, Youth and Their Families. At the time of the Youth Summit, we carried the virtual summit on the Web. You could register on line to volunteer with over 30 agencies. It was a very successful project. We had a very good partnership with the MOCYF. This collaboration was named in the top 100 by the Ford Foundation.

We have now joined with the City in a contract for a youth line that will operate 12 hours a day 7 days a week. It will be a phone-based resource and referral line. This will be the first in the Bay Area, and it will be the most technologically-advanced in the city.

Let's say there is a 15-year-old student at Thurgood Marshall school, who thought he passed the math test but flunked it, and decides he wants a math tutor. He can call the Youth Line where the phones will be answered by youth, ages 16-22, supervised by adults. He can say, "I live in Bayview, and I need a math tutor." Those two criteria will go into the computer and a map of San Francisco will appear and then information will be given about the location of tutoring programs, plus background information on other programs at the same center.

Let's say the youth has a math tutor, but is still not doing well and is scared to take his report card home to his mother. He will be able to call Youth Line and talk to a peer with 80-100 hours of training in active listening.

But if peer counseling escalates to a crisis, our counselors will be able to identify the crisis and make a human connection to specific crisis services. If someone is suicidal they'll be connected to Suicide Prevention. In a case of domestic violence, they'll be referred to Casa de las Madres. Someone who is gay or lesbian will be referred to LYRIC.

Currently 411 or 911 are the only places to call, but there is no peer, human voice there.

Our program will be technologically advanced. The phones and computer will be integrated. All the hot numbers will be on the computer screen. So the counselor can automatically dial, say, Suicide Prevention. Youth Line was pioneered in New York City, 24 hours a day, with a much larger base of teens. They were able to convince Mayor Dinkins this was a great program and received $1 million in city funds to set it

up and $800,000 a year to run it. But then Dinkins lost the election and the funding was in jeopardy.

In San Francisco, there will be significant commitment from the city, but it will be a public, private partnership. The response to Youth Line has been really, really strong. The Giants are going to sponsor an event for Youth Line.

The database and mapping system are almost complete. We'll work with the Dept. of Public Works over the summer to polish the database. We plan to launch the Line in the fall.

Ms. Block: How will you advertise the line? Mr. Singer: On buses, with billboards, with PSA's on radio and TV. We'll do a PR campaign. We'll also distribute information in every school in the city. We have a great partnership with the schools. We'll also distribute information through Juvenile Justice, DHS, and the mental health system. We have budgeted for a Director of Outreach. And we have a design company that is committed to *pro bono* work worth about $100,000.

Ms. Traveler: Where are you getting students to operate the Line? Mr. Singer: A year and a half ago, 150 youth, through Youth Making a Change at Coleman and the Mayor's Office, went out through every neighborhood to find resources committed to youth. We will be recruiting some of these youth. We'll be hiring 45 youth part-time. We'll also recruit among the peer counselors who are already at the schools. Over the summer, we'll be providing 80-100 hours of training. The two founders of the Youth Line in New York City will be working with us on the training.

A question came from the public about language capabilities. Mr. Singer: We will be able to service every language. We'll have people who speak Spanish, Russian, Cantonese and Mandarin working on the line. For other languages we'll us the AT&T translation service, where a third party will serve as the translator, and will maintain confidentiality.

Mr. Shipley: Youth are active after midnight, why stop there? Mr. Singer. Youth Line is first an information resource, and secondarily a peer to peer line. It's not a crisis line. It will never be promoted as that. In Boston and New York City, they get very few information call between midnight and 8 a.m. The majority are crisis calls, but we are not going to be a crisis line.

Ms. Rossman: If a youth calls and is in crisis, can they press 1 and be connected with Suicide Prevention? I would like to see that the caller wouldn't have to hang up and re-dial.

Ms. Gilleran: Where have you found private funding? Mr. Singer: The Giants have promised a fundraiser. Levi Strauss Foundation has expressed interest. There is no firm commitment yet, but I will guarantee you this service will be up and running in the fall.

A process is in place. We've started discussions with funders. We are developing 3- to 5-year commitments. Almost assuredly there will be a considerable annual appropriation from the City.

Ms. Gilleran: It's a very beautiful plan, I'd love to see it work. Ms. Traveler. It's a wonderful plan. Since it's information-based, are you working with the United Teachers of San Francisco and other teachers groups like the CTA? One problem is that as a teacher you get thousands of flyers at school. I'd suggest targeting 3 high schools and get them informed. I would like to see more of crisis counseling as part of it, because the rate of suicide among teens is the highest in our state and in our nation.

Mr. Singer: The teachers union is a wonderful idea, an important dissemination path. Teachers are among the most important service providers. I was a teacher before founding CHALK. I know about getting overwhelmed with flyers. I threw away a lot myself. We will be working on making the flyers effective. We will hire youth to go talk with teachers and get them to talk with the kids.

Dr. Beauford: Is there any mechanism to monitor and follow up on calls. Mr. Singer: Most of the data collection is in the moment of the call. I'll be really honest with you, we're going to sit down and talk with the founders of Youth Line in New York about follow up. It would be wonderful to have follow up data, but I'm not sure we'll be able to do that.

Ms. Block: I'm interested in the training. People often call with an information question as a way of getting into a deeper issue. Mr. Singer: This is one of the largest youth employment programs. I think it will be enough to get them up and running on the information and peer counseling. But crisis counseling would probably be too much to ask. But during training, we're talking about bringing in Suicide Prevention. We'll also provide training on how to handle the persistence calls and sex calls which go with any talk line.

Ms. Rossman: Will there be any provision for the peer counselors to talk with mental health counselors if they have to take difficult calls. Will they have someone to process with? Mr. Singer: We anticipate there will be crisis calls we can't transfer, we will have MSW's there--our Deputy Director is an MSW and the Supervisor is an MSW.

Ms. Gilleran: How will service providers be able to handle new referrals? Mr. Singer: This line will be a boon to service providers. They'll know what kids are asking for and needing. This will be a matter of youth advocacy. Programs that experience overcrowding as a result of our referrals, will be able to tell the City and foundations what the needs are.

Ms. Gilleran: I worry about backlash against CHALK if kids ask for help, but the programs you refer them too are full. Mr. Singer: All the programs in the database will be alerted to Youth Line's services.

Dr. Moses: This sounds like a wonderful program. But there are areas of the city with big needs, such as Bay View Hunters Point. How do you plan to reach them? Mr. Singer: We're going to get this information out to every corner of the city. It would be inexcusable not to, and also there is a need to prove the value of our services. We'll have a database of 2,000 children's and youth services, and they will each get flyers and stickers to give to their students. Also the libraries and beacon centers.

Dr. Beauford: What is the length of employment for the youth. Mr. Singer: My vision is that the youth trained in the summer will be employed until we have to do a training again. We'd like to build youth leaders. We want them to stay with us 2-3 years. Ideally we want retention. We'll be paying them well—paying above minimum wage.

There was a question about the youth working on the Line keeping up their grades. Mr. Singer: They will have to keep a 2.0 average to stay on the line. Ms. Rossman: I think it's good that you set the average at 2.0 because then you'll have youth working on the Line who know what the struggle is like.

Mr. Singer: You have my word that I'll come back to the MHB prior to launch in the fall to get ideas about places to disseminate information. Please feel free to send or e-mail suggestions.

Mr. Kalman: What is the budget? Mr. Singer: I'm happy to disclose it to you. It's half a million annual budget. A good portion of it will be spent on youth employment and training. This is not the most inexpensive program in the city, but it will be worth every single penny we spend on it.

IV. MHB COMMITTEE REPORTS

Executive Committee
No report

Children's Committee
Ms. Leib reporting for Ms. Jones: We're still working on Transition Services, finding out what there is, what there isn't, and who's doing it.

Program and Services Committee
Ms. Gilleran: At the last meeting, we had a presentation by Mary Louise Flemming from the Mental Health Rehabilitation Facility, who brought with her her top management team. The MHRF has been up and running for 8 months. They feel they have a good team. They have found what they are doing to be very challenging.

They are working with people who have been hospitalized from 7 to 25-30 years. Socialization is a big challenge. They feel they are making progress. They are involving families as much as they can. They showed us slides of the facility. It's very beautiful. We felt proud to have it as part of our services in San Francisco.

We asked about their program of peer counselors and still have questions about that. We asked about the ethnicity of the staff. They said Hispanics are over-represented. Only 4% of clients are Hispanic. Whites are under-represented. Sixty percent of clients are white. There is a fairly even representation otherwise. But they need more Asian staff who can speak Cantonese. A lot more questions need to be asked. We would like to have them come back again and ask more probing questions.

Ms. Traveler: We need to get more into the personnel and program issues.

Dr. Shue: Only one person has gone home in the time they've been open.

Public Education and Outreach Committee
Ms. Leib: The Committee has changed its name to Public Education and Outreach. We had a terrific Opening Reception for the art show. Artists came through 100%. And our co-sponsors came through big time. I was disappointed though that only half of the members of the MHB could see their way clear to go to the opening.

Mr. Shipley: I really appreciate Maria and Rich for handling this show.

Ms. Leib: I was so embarrassed in front of the artists. I was barely able to show my face. This art show was not a whim; it's the Board's work. Mr. Shipley: You're walking on my appreciation.

Ms. Chartrand: People have got to do what they've got to do and making them feel guilty is not cool. For me the art show was a good experience. This was a way for us to come out and show our stuff. I really, really enjoyed the opportunity to connect. There was a little boy who couldn't speak, who heard me during the program and came out later and touched my name tag to communicate with me. We had such a special connection, I almost cried.

Consumer/Family Member Task Force
Mr. Leoni: CTF met three times in the last month, April 15, 22, and May 13, to discuss the implementation plan for mental health managed care.

Community Advisory Board
Mr. Shipley: I'm the Vice Chair of the CAB. We discussed the smoking policy. No smoking is allowed in the hospital. A committee was formed to come up with a smoking policy, and it's not quite finished yet. It's very difficult.

Mr. Leoni: There's new research that shows that cigarettes and nicotine helps with schizophrenia and the side effects of psych meds. A policy that denies smoking is cruel. Ms. Planck: I doubt if in the midst of a psychiatric crisis is the best time to stop someone form smoking. Ms. Traveler: Smoking can be calming and an ice breaker. My sister was

just in St. Luke's Hospital, and they can smoke in the plaza there. It's a difficult issue, but I have seen my sister calm down just smoking that cigarette.

Ms. Rossman: In my opinion there have been numerous issues in the last months which have not been presented in the best avenue. If there are issues, perhaps it would be best to write them in letters, especially when it has to do with the internal structure of the Board and is not a public issue. We need to find a way to facilitate internal issues better. It's inappropriate to do that in public and it's very uncomfortable for people.

Ms. Traveler: I recommend that internal issues be written in a letter and sent to the Executive Committee. Ms. Block: I think that's a good suggestion and we'll put it on the Executive Committee agenda. Thanks to Alex for bringing it up and thanks to Lora for your suggestion.

V. VISIT WITH SUPERVISOR AMOS BROWN

Supervisor Brown was unable to attend.

VI. REPORT OF THE DEPUTY DIRECTOR

Collins Munns reported as follows for Jo Ruffin: The Foster Care proposal the MHB took to the Mayor's Office has been referred by to DMS. The grant funding for the program expires next April. DMS will be working with the MHB to make sure funding continues.

Jo wanted to express her appreciation to the Board for hosting a special meeting on the implementation of mental health managed care. Many good ideas were brought up, many of which have gone into the plan. She also appreciated the MHB Chair's protocol to make sure everyone would be fairly heard.

Forensic services has been transferred to the Community Health Network (the DPH integrated delivery system). Jo knows the MHB has a longstanding interest in Forensics. She suggests a meeting including herself, Dr. Joe Goldenson, the Director of Forensics, and the MHB on the treatment of African Americans in the jails.

The consumer representative on the Leadership Work Group, Dave Wilkinson, resigned due to a promotion at work. Steve Leoni has been asked to join the LWG in Dave's place.

Jo continues to be interested in doing an orientation for the Board to the services and structures of DMS. She would be glad to arrange that if the Board is interested. It could take place either during a Board meting or in a special meeting.

Ms. Gilleran: We had Jail Psych Services here a year ago to do a presentation, and agreed on setting up a committee to coordinate services for mentally-ill people in forensics. Ms. Block: You still want the committee to meet quarterly? Ms. Gilleran: Yes.

Ms. Block to Mr. Munns: Could that request be relayed to Jo—the interest in forming the committee, which is to be a DMS committee. Ms. Planck: Jo had actually offered this.

Ms. Block then asked how many members would like to hear a presentation from Joe Goldenson as soon as possible. There was a general consensus to do that.

Dr. Moses: Could you update us about the proposal for the implementation plan? Mr. Munns: The latest draft has been submitted to the State, so we are waiting for the response from the State. We can still include new changes and send them in to the State all along the way. Dr. Moses: April is still concerned about cultural competency and domestic violence issues. Mr. Munns: Materials can be submitted to me tonight.

Ms. Chartrand then read her statement on cultural competency. Her recommendations are listed in the resolution below:

Dr. Moses asked Mr. Munns for his opinion. Mr. Munns replied that he would need to review the proposal in closer detail. He noted that the person responsible for the recommendations would probably be Tina Yee.

Mr. Leoni: I wanted to add a context to this discussion. Part of the problem is that the State regulations on cultural competency have not come through yet. This is in part because groups in San Francisco were upset about there not being enough attention given to cultural competency. There is a special statewide group now working on cultural competency requirements.

Ms. Traveler: We could simply recommend April's plan and send it to Ms. Yee.
Dr. Shue: I think it's additive. She reveals more aspects of quality control.

Ms. Chartrand then read her second statement on domestic violence in relation to mental illness. Her recommendations are listed in the resolution below.

Ms. Planck noted that some of the recommendations were not in DMS's power to do.
Ms. Chartrand: Whatever you can do, go to that limit. It will help save a lot of lives.

RESOLUTION (MHB-97-14): Be it resolved that the Mental Health Board adopt the following five recommendations proposed by April Martin Chartrand on cultural competency:

1. Develop statewide/city experiential culturally aware classes, workshops and retreats (ceu). All schools will institute this in their study plan as a necessary vehicle to meet the ongoing cultural openness necessary in California. This will allow for personal growth and transformation professionally;

2. Develop and institute a cultural competency task force in the workplace. Train employees on an ongoing basis;

3. Develop PSA/Media Edu-tainment campaign to assist in public awareness and education. Also, have task force teams do education of the public and schools;

4. Develop ongoing public education in neighborhoods, churches, street fairs, interfaith networking, etc., annually, quarterly and monthly;

5. Develop an outcomes component for Cultural Competency Education/Development into 2000+;

and the following six recommendations on domestic violence;

1. Conjoin the out-sourcing of Mental Illness and Domestic Violence recovery issues (Education in a manner that provides direct services, i.e., evaluation, prevention (rehabilitation for both sides;)

2. Require all California doctors/hospitals to ask if both sides have been/or are abusing self or anyone emotionally or physically on the intake forms and in doctor/patient discussions. This will also assist with medical evaluations on non-visible symptomatology;

3. Edu-tainment campaign for prevention; education and PSA's on the relation of domestic violence, anger or mental and physical illness;

4. Provide healthcare providers with information, education classes, requirements in the schooling;

5. Provide alternative healing modalities on domestic violence and develop a step program for wellness and healing;

6. State-mandated classes and ongoing classes on domestic violence and mental illness;

and be it further resolved that the Mental Health Board request that these recommendations be added to the DMS implementation plan on mental health managed care. (Passed.)

Ms. Traveler: We need to go back to the Consent Calendar, Attachment A. I would like for us to strengthen the statement. Instead of just saying that some of the housing should be reserved for the mentally ill, a certain percentage should be included, perhaps 50%. Perhaps a little subcommittee could make this as specific as possible.

Ms. Block: We'll bring up the idea of the subcommittee in the Executive Committee. Would you be willing to chair it? Ms. Traveler: Yes.

VII. PUBLIC COMMENT

Mr. Kalman reported on the issue of the need for recreation programs for the mentally ill through the Recreation and Park Department.

Mr. Canedo: I think it's really cruel to force someone to quit smoking when they are having a nervous breakdown. You're told to quit just when you need to smoke the most.

VIII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:37 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3567

MEETING OF THE FULL BOARD

Wednesday, June 11, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.—Please note new meeting time!!

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AGENDA:

10 min. **I. CALL TO ORDER, INTRODUCTIONS**

10 min. **II. CONSENT CALENDAR**
- Approval of May Minutes

45 min. **III. SPECIAL PANEL: Acupuncture and Mental Health**
- Roy Crew, Director, Office of Self Help
- Nsoah Chionesu, Acupuncturist, Bayview Hunter's Point Foundation
- Client, Bayview Hunter's Point Foundation (to be confirmed)
- Muin Daly, Director, Acupuncture Services at Jail Psychiatric Services

30 min. **IV. MHB COMMITTEE REPORTS**
- Executive Committee (Attachment A)
- Children's Committee (Attachment B)
- Program & Services Committee
- Public Relations
- Consumer/Family Member Task Force
- SFGH CAB
- DMS Committees

15 min. **V. REPORT OF THE DEPUTY DIRECTOR**

10 min. **VI. PUBLIC COMMENT PERIOD**
Members of the Public will have up to 3 minutes to comment on any issue within the MHB's purview, except for issues on which they have already commented.

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

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DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
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52

97

UNADOPTED MINUTES

Wednesday, June 11, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Norma Block (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Peggy Gilleran, J.D.; Lois A. Jones; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Lora Traveler, M.A.

BOARD MEMBERS ON LEAVE: Anita Burton; Maria Leib; Alex Rossman, M.S.W.; Sylvia Shue, Ed.D.; Paula Wilson.

BOARD MEMBERS ABSENT: Supervisor Sue Bierman

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ADJUNCT BOARD MEMBERS PRESENT: none

PRESENTERS:
Roy Crew, Director, Office of Self Help
Muin Daly, Director, Acupuncture Services at Jail Psychiatric Services

OTHERS PRESENT: Jo Ruffin (DMS); Collins R. Munns (DMS); Alfredta Nesbitt (Bayview Hunters Point Foundation); Mike Wise (Consumer; Residential Care Task Force); Dwight D. Darkes (Consumer); Robert A. Schreiber (Swords to Plowshares); Mark Adamek (Spiritmenders, Community Advisory Board); Emerick Kalman (Family Member); Marion A. Keller; Armando Sosa (Community Advisory Board, Dept. Psychiatry, SFGH); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Ms. Block, Chair, at 6:31 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-15): Be it resolved that the minutes of the Mental Health Board meeting of May 14, 1997, be approved as submitted. (Passed)

III. SPECIAL PANEL: Acupuncture and Mental Health

Ms. Block: The Executive Committee has been interested in alternative healing, and we are happy to have a panel on acupuncture and mental health. We have also decided to try an experiment tonight and add 3 minutes of public comment to each section of the meeting in order to give the public more time to speak. That's 3 minutes total for all the public comment. We will also have the regular public comment period at the end of the meeting.

Roy Crew is a former peer counselor at San Francisco General Hospital and a former member of the Mental Health Board. He convened the Consumer/Family Member Task Force of the MHB. He is currently the Director of the Office of Self Help, and is the recipient of acupuncture for a period of about ten years.

Mr. Crew: I've had four practitioners in the past 10 years. I sought out acupuncture in response to HIV eleven years ago. The mental health benefits of acupuncture came as a bonus.

My first practitioner was a female from Quan Yin, one of the leading acupuncture centers in the city. After she left, my second practitioner was a male from an acupuncture school. My first practitioner was wonderful. She spent a great deal of time with me. The second one was a bad experience. He was afraid of HIV. Back then we didn't know as much. You can get bad M.D.'s and you can get bad acupuncturists. With my second practitioner, the needles hurt, but I also got blisters from the moxibustion, and that shouldn't have happened.

My third practitioner was from mainland China and the most interesting person I've ever met in my life. She read my palm, took pulses in both arms. She didn't worry about AIDS.

I had been diagnosed with schizoaffective disorder. My biggest problem is manic periods and depression. She didn't understand this. So I explained it in terms of not being able to sleep and not being able to leave home. She said, "Oh, we have that in China. We can fix that." I thought, "Oh, sure." I had taken so many pills to treat those problems. But I would come in to her office after 3 days of no sleep, in a manic period. I would be out after ten minutes of treatment and would sleep for two hours in her office. When she woke me the mania would be gone. Then she'd give me herbs.

With depression the hardest part is just getting to acupuncture treatments. With this problem she also helped me to sleep, and the next morning, I'd get up and be out early, ready to meet the world.

My HIV condition improved. Over a couple years she was changing the way I perceived myself, and the way I perceived illness. She finally went back to China.

My fourth practitioner is a Tibetan who uses herbs more than needles.

The first step is to clear the organs. I had a bad experience with Haldol and decided to not take psych medications and had hell to pay.

Diet is an important part of healing. It has a lot to do with mental health. It's important to get enough protein and to stay away from caffeine.

Going to acupuncture for mental health changed the way I live. Now my body tells me if I need more veggies, more salt, or more rest.

In acupuncture the needles are put into meridians and are rolled a little bit to stimulate the point. Moxibustion is like big old joint being lit, and the acupuncturist puts it near the needle till you say ouch and then she pulls it away. This is also done to stimulate the point. You can also attach the needles to a little box that runs a current to the needle and can cause extra stimulation at the meridian.

If you are going to chose an acupuncturist, make sure that they have their own supply of herbs on site, so you don't have to go out and find them. This is especially important for people who have difficulty getting around town. It's important to be able to relax after the appointment.

Does it hurt? There are a couple of places where it hurts, but not many. Mostly the needle just goes into the skin. Sometimes it goes into the muscle.

In terms of the value of acupuncture for mental health, it helps control sleep patterns, depression, and to some extent psychosis. It helps you look at the person's whole life.

I've been HIV+ for eleven years and have had no opportunistic infections and no major psych episodes, and I've not been taking psych meds for the past 7 years.

Ms. Block: Muin Daly works for ARTS—Acupunture and Recovery Treatment Services. She is the Director of Acupuncture Services for the San Francisco Sheriff's Department, former Director of Acupuncture Treatment Series at Sitike Counseling Center in San Mateo County and a founding member of Acupuncture and Treatment Services. She is currently co-chair of the N.A.D.A. Training Committee as well as regional coordinator.

She has participated in the development of a variety of treatment programs targeted for women who are suffering from Post Traumatic Stress Disorder or who are in crisis situations and in danger of relapse, such as survivors of rape, domestic violence, and childhood sexual and physical abuse.

She is also a certified HIV counselor and is currently co-facilitating a group for incest survivors who are in recovery from chemical dependency. She worked as an AIDS educator and performed acupuncture for the Empower Program in Thailand, serving the sex industry workers in Bangkok.

She also provides training in the area of substance abuse acupuncture to licensed candidates seeking National Acupuncture Detox Certification.

Ms. Daly: One of my colleagues, a founder of ARTS, Dr. Carol Francoise is here in the audience. I want to talk about how we have been using acupuncture for the Sheriff's Department and at public health centers. I interned at Quan Yin, a wonderful clinic, and introduced acupuncture to fellow students in the 70's.

I'm now working for ARTS. We do auricular acupuncture, which means we primarily use the ear. The reason is that it is so accessible. We are working with people in the public health system and the criminal justice system, and auricular acupuncture makes our access to those systems easier.

In acupuncture we are not interested in the name of the disease, we're interested in where the imbalance is. The way I have a headache and the way someone else has one can be very different. We need to deal with the individual. Chinese medicine does not make a division between the spirit and the body. The diagnostic procedure is one of the beautiful things about Chinese medicine.

ARTS was formed 4 and a half years ago so we would be able to break into public health. We were the first ones to be able to break into the Sheriff's Department, which happened originally through a grant. Under our first grant we worked with 45-50 women in a pod who were in recovery. Ninety percent of them were African American, they were between 18 and 35 years of age, and most had children.

Within a month the Sheriff asked us to go into the next pod and work with the female inmates there. We did well in that pod, too, which means in criminal justice terms, we were seeing behavioral changes. There were fewer people for pill call; there were fewer violent incidents. The women showed that they wanted to be in a program.

In a mental health facility, we add acupuncture as a facilitation, not as the primary health care. My work helps facilitate the person's day. If you have acupuncture when you get up, your mind is clearer, and you have more softness and gentleness in your approach to your program.

Now we are working in 7 different pods treating men as well as women. We educate everybody, including the Deputies and the staff, so there's a safety net inside the agency. We wanted to bridge the fragmentation and pull people together. When our grant ran out after 3 years, the Sheriff's Department continued the program with their own funds.

We also get to treat staff. The inmates tell us which staff to treat and we treat them. It's useful, it's a stress reduction.

What we offer people in jail is a lot more limited than what we can do outside. But we can help people understand how their own system is working or not working. This makes things interesting instead of scary. When you're afraid of yourself, you're afraid of your own recovery. We have a network of clinics so people can keep on with their treatment after they get out of jail. We are part of the National Acupuncture Detox Association (NADA), which has a protocol for this kind of treatment, which involves 5 short needles in each ear.

We started doing detox, but are now dealing with the person's whole life. We've opened up to all kinds of people.

The idea for what we do started in the Bronx, when the Black Panthers and Young Lords went to Michael Smith and asked him to look into acupuncture and he did. NADA trains people who are in recovery and have been through treatment. After years of training in school, it is a humbling experience to see acupuncture work in practice.

The auricular piece is very powerful in its simplicity. It's successful and its cheap. We call it Chinese medicine because China wasn't colonized and didn't have it's medicine taken away from it. But the same points are used all over the planet. Some people use the pressure of their thumbs, others use handles. China had excellent metal workers, so they got into needles.

Along with the needles we also use a detox tea, which is a simple herb mix, which we make with North American herbs.

Sometimes we use seeds on the ear, both for addicted babies and addicted mothers. Adults can take seeds with them for the weekend and press them on their ears on the points where we treat them with needles.

Sinus trouble can be a matter of tears being held back. Every tear drop has 280 toxic elements. So crying is a wonderful way to clear out the body. It's just that it can be hard to hear it from an addicted baby for 14 hours at a time.

Mr. Crew: Most centers do some kind of sliding scale. Medi-Cal will pay for 2 visits a month to see an acupuncturist.

Dr. Moses: I have an article to hand out by Michael Smith about using acupuncture to stop smoking, but all kinds of good things started happening for people.

Dr. Beauford asked about the efficacy of acupuncture with children. Ms. Daly: There are lots of tools for stimulating children's meridians other than needles. There are seeds, scraping, wheels we can roll up and down. Some schools teach an in and out method, putting the needle in then pulling it out immediately. There are lots of ways to diagnose children. You can note a lot of imbalances in their fingers, you can also read their tongues or their organs.

I don't think there's anyone who's studied Chinese medicine who doesn't have good background in pediatrics. But you want to find someone with lots of experience in working with children, and most practice is done with adults.

In China, the allopathic and Chinese clinics are conjoined. The Chinese have produced reams of research to convince Westerners that their medicine works.

It's important in working with former addicts to explain the difference between a hypodermic needle and the acupuncture needle.

Dr. Moses: I want to commend you for your work. I also work in the jails in the psych units. I did a site review last year at the Bayview Hunters Point Foundation and interviewed 24 clients and many of them talked about acupuncture and liked it so much. They liked it and weren't forced to do it. Are your clients voluntary?

Ms. Daly: Absolutely. They are all voluntary. NADA is committed to choice. Dr. Moses: I think this is a really good idea. And cost-effective.

Ms. Daly: I'm sure that's the first word Sheriff Hennessey heard, was cost-effective. In meeting with him and his staff, we offered to give the treatment to them, and that's all it took. The Sheriff said that if he felt that way and the inmates would feel that way after a treatment, that it was worth the money.

It's very intimate. We're in a person's ear for only a minute, but it's intimate. And we are not the drug counselors. The person is making a choice to do something for themselves.

Dr. Moses: Are the females affected more than the males? Ms. Daly: I don't think there's a difference. The men need a little more reassurance, but that's the only difference.

Ms. Gilleran: There is a study showing a helpful effect of acupuncture on tardive dyskinesia. Ms. Daly: Yes. They are following up that study with more studies. It's hard to do blind studies with acupuncture. We don't like to do that, and how do you do that—stick the needle in the wrong points?

Mr. Crew: The Chinatown/Northbeach Mental Health Center has found very good results with acupuncture.

Ms. Gilleran: Whatever exposure I've had to alternative medicine has involved nurturing attention and respect for the body—treating the body with reverence. What proportion of the healing process is this nurturance?

Mr. Crew: I'm glad you asked that question. In Western medicine people are so afraid to touch one another. it implies so much. But in acupuncture, the first thing they do is take

pulses, and you stick out your tongue. They are looking for 3 different pulses and checking organs. So this bonding starts right away. And with the needles, all the touching that is going on, is the start of the nurturing process. You really start to relate to the person treating you. You can shake a person's hand and tell if they want to or not. And the same is true with acupuncture. You can tell they really want to heal you. They want to show you how to live your life better. The lights are dimmed. In some offices there is music.

Ms. Daly: In China, the clinics have bright lights, and 70 people are there at the same time, and it seems like an assembly line—but they believe in their medicine.

Public Comment
Mr. Wise: So much is written about so much of psychiatric illness being related to chemical imbalances, especially in the brain. How does acupuncture affect the chemical imbalance.

Ms. Daly. It absolutely does. Acupuncture which is different than herbology or nutrition is more than anything about bringing the system back to balance. Herbs or nutrition are about bringing energy in. Drugs are about taking energy out. Acupuncture brings the system back into balance with a wonderful simplicity. Acupuncture doesn't bring in or release anything. It just brings the body back into balance.

Dr. Moses then publicly recognized Alfredta Nesbitt, the Director of the Substance Abuse Program for the Baview Hunters Point Foundation, who was present in the audience. In terms of action, he said that acupuncture was a very good idea and that the Board might recommend to DMS to expand it and make more money available to fund it.

RESOLUTION (MHB-97-16): Be it resolved that the Mental Health Board go on record in support of acupuncture treatment as a valuable part of mental health treatment, and urge the Division of Mental Health to support and expand acupuncture services. (Passed)

IV. MHB COMMITTEE REPORTS

Executive Committee
Ms. Block reviewed Attachment A, regarding a proposal from the Executive Committee on how the Board should handle internal issues.

Ms. Chartrand: What I would like to see is an ethical code of conduct drafted for the Board. It should include how many warnings a person would get. It should be clear about what the problem is so we can solve it. And if there is a problem, what is the follow up? Is a letter sent?

Ms. Jones: The resolution was written in a vague way since it's important that members get to address the whole Board. A Board member has the right to bring a grievance to

the table. But not a right to bring it up meeting after meeting. I can't stand people who carry grudges. We don't want to prevent people from stating issues, but this should not disrupt the business of the Board.

Ms. Chartrand: I think an ethical code would include: no profanity, no personalizing, and no proselytizing. Ms. Gilleran: I agree that there needs to be more definition. It's rare that people would violate the code, but when we are authentically working there will be spontaneous reactions. We can't sanction people lightly for genuine reactions of spontaneity. But there need to be definite guidelines about what will be tolerated.

Mr. Shipley: I agree that there needs to be a set of procedures. I'm a very procedurally-oriented person. I like to see procedures in black and white, and I think that would make for a more cohesive Board.

Ms. Block asked Ms. Chartrand if she had examples of ethical rules from other Boards to use as a starting point. Ms. Chartrand said she would bring some in.

Ms. Jones: I don't want it to get lost that disagreement of ideas is a healthy thing for a Board. We want people to speak about their ideas.

It was decided that the issue would go back to the Executive Committee for further development.

Children's Committee
Ms. Block: The Children's Committee has come up with what I think is a wonderful idea for a conference.

Ms. Jones: The month before last, the new Director of Special Education for the School District came to speak with us. San Francisco has taken a big hit from the federal government for not providing services for transition age youth, between 16 and 22 years of age. Often when these young people become adults they lose their services. We felt it was time to stop talking about it and do something. This is a growing problem that is going to haunt us if we don't do something about it.

The proposed mini-summit is an opportunity to get public health, mental health, social services and other agencies together. We also want the presiding judge of the juvenile court. The mini-summit would not be for the public. We'd ask people to check their turf battles at the door and work together to keep these kids out of jail.

Ms. Chartrand recommended asking Wells Fargo to provide the conference space pro bono. Ms. Jones said she was already working on that.

RESOLUTION(MHB-97-17): Be it resolved that the Mental Health Board approve in concept and for further exploration, the Children's Committee proposal to host a Mini-Summit on Transition Services, involving the San Francisco Unified

School District, the Department of Public Health, the Department of Human Services, and other relevant departments and agencies, to be held in the fall of 1997. (Passed.)

Ms. Ruffin: Under the new contract for fiscal year 97/98, DMS and the MHB will be working together on special events such as this conference. Sai-Ling has already been working with the Children's Committee on this.

Program and Services Committee

Ms. Gilleran: The programs we've put on the list for program reviews so far are: Patients Rights Advocacy Services; the 3 new Single Point of Responsibility Programs (UCSF/SFGH, Westside, and Mission Multicultural Assertive Community Team); the Mental Health Rehabilitation Facility; Conard House's Washburn Hotel; Crestwood Stockton (if DMS will continuing using the facility)

Consumer/Family Member Task Force

Mr. Shipley: We had a 40-minute presentation by Rinna Flohr on the new consumer handbook which will be used under managed care. We'll continue discussing it at our next meeting as well. We also had a discussion about forming a unifying organization of peer counselors in San Francisco. There was a discussion about the monopoly regarding peer counseling and training. A subcommittee has been set up to deal with it.

Community Advisory Board

Mr. Shipley: We had a 40-minute training on PARK, which is about how to more humanely deal with clients reaching an assaultive level. We also had a presentation on quality assurance and grievance procedures. The bake sale for the clothing project was a great success raising over $1,000.

V. REPORT OF THE DEPUTY DIRECTOR

Jo Ruffin: Dr. Sandra Hernández is leaving her position as Director of Public Health at the end of July. She'll be recommending to the Mayor some candidates to replace her. The Health Commission will probably consider naming an interim director. There's hope a replacement will be named before Dr. Hernández leaves the Department.

We are very sorry she's leaving. She had to made a tough personal choice about having a life. She'll continue with the Blue Ribbon Committee and will continue to serve on the Health Authority Board at the Mayor's representative. She'll also continue to serve on the Presidential Commission on Healthcare.

The reorganization of DPH will continue as planned, and I'll keep you informed of any changes.

The Health Department's budget was submitted to the Mayor last week. A public hearing is set for June 21st. We are hoping that for mental health we will see an additional $2 million in funding so we can provide services for the indigent mentally ill.

We have the same services now for the seriously mentally ill whether they are Medi-Cal or indigent. But under Medi-Cal managed care, the expanded medical necessity applies only to people on Medi-Cal.

We have a meeting set up with Dr. Joe Goldenson, Director of Forensics, and Peggy Gilleran of the MHB. Toye Moses has also been invited. We'll report back to the Board.

We submitted out implementation plan for managed care to the State, but haven't heard back yet. We expect the start up date will fall back to January 1, 1998, from October 1, 1997. But we are keeping the pressure on the work, so we don't end up doing everything in the last minute over the holidays.

We offer acupuncture services in some of our clinics. I will be glad to get a list and respond to your letter regarding expanding acupuncture services.

The Lyric Hotel will be opening. It is a 58-room support service hotel for mental health clients. This is a program supported by DMS.

We had a Town Hall meeting with DMS staff to bring them up to date on managed care.

VI. PUBLIC COMMENT

Mr. Schreiber: At the Bed Committee, we've been getting refusals based on the county the Medi-Cal card is issue in. Can we use the Grievance Procedure to protest this? If someone comes from LA and can't get their Medi-Cal card transferred here they are caught in a Catch 22.

Ms. Ruffin: Yes, you can use the Grievance Procedure or grieve it to me directly. I am currently writing a letter to the Coalition on Homelessness about this issue. You are right that it is not until Medi-Cal is transferred that a person is eligible for county services beyond emergency services. There is no good answer to this question. We only have 180 residential beds, which is not enough for everyone who needs them.

Mr. Wise: I've been kind of a pain in the butt about the STEP program. I'm glad to see the MHB is going to review it. I presented my concerns at the Residential Care Task Force. People seem to be covering up. The program description for the STEP program was watered down in the contract. Now they are asking for $60,000, but they are offering less than what we originally designed for $50,000. I've had to go to outside places. I did take this issue to the City Attorney. Maybe I didn't have to go there. Are you going to come forward with some kind of review.

Ms. Ruffin: I am reviewing the complaint and am preparing the report. I haven't asked the City Attorney to investigate it. I am investigating it myself.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:28 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, July 9, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

10 min. **I. CALL TO ORDER, INTRODUCTIONS**

10 min. **II. CONSENT CALENDAR**: All matters listed on the Consent Calendar are considered routine and will be acted upon by a single vote of the Board. There will be no separate discussion of any item on the Consent Calendar, unless a member of the MHB so requests, in which case the item will be removed from the Consent Calendar and considered as a separate item.

- Approval of June Minutes
- SAMHSA Grant Renewal - See Attachment A.
- Performance Contract - See Attachment B.

20 min. **III. SMOKING POLICY FOR HOSPITAL PATIENTS:** See Attachment C.

PUBLIC COMMENT - 3 MINS

35 min. **IV. MHB COMMITTEE REPORTS**

- Executive Committee - Retreat - Discussion - Att. D
- Children's Committee
- Program & Services Committee
- Public Relations - Speakers' Bureau - Discussion - Attachment E
- Consumer/Family Member Task Force
- SFGH CAB
- CALM Bd.
- DMS Committees: Leadership Work Group, Managed Care, Quality Management, Pharmacy & Therapeutics, Committee for Culturally Competent Systems of Care

PUBLIC COMMENT - 3 MINS

30 min. **V. REPORT OF THE DEPUTY DIRECTOR**

PUBLIC COMMENT 3 MINS

15 min. **VI. PUBLIC COMMENT PERIOD**

Members of the Public will have up to 3 minutes to comment on any issue within the MHB's purview, except for issues on which they have already commented.

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UNADOPTED MINUTES

Wednesday, July 9, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Toye Moses, Ph.D., M.P.H. (Acting Chair); Jim E. Beauford, Ph.D.; Anita Burton; April Martin Chartrand; Peggy Gilleran, J.D.; Alex Rossman, M.S.W.; Mickey Shipley; Sylvia Shue, Ed.D.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Darwin Dias; Lois A. Jones; Maria Leib; Paula Wilson.

BOARD MEMBERS ABSENT: Lora Traveler, M.A.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni

OTHERS PRESENT: Jo Ruffin (DMS); Collins R. Munns (DMS); Chester Villalba; David Smith; Mike Wise (Consumer; Residential Care Task Force); Dwight D. Darkes (Consumer); Robert A. Schreiber (Swords to Plowshares); Emerick Kalman (Family Member); Mary Sue Planck (MHB); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Dr. Moses, Acting Chair, at 6:36 p.m.

Dr. Moses announced that Norma Block had resigned as Chair and as a member of the Mental Health Board, due to the demands of her new job and the commute to Berkeley. He said that she had done a wonderful job as Chair, and that she would be missed.

He then explained that since the Vice Chair, Maria Leib, is on leave until October 1st, the Executive Committee had asked him to step in as Acting Chair until that time.

Ms. Rossman asked when Ms. Block resigned, and Dr. Moses responded that it was during the past week. Ms. Rossman: I wish she had been able to be here for one last meeting for closure. It would be important for MHB to write a letter to her saying how much we've appreciated her service.

Ms. Gilleran: I'd like to suggest that we have a gathering to recognize Norma, if she would like that, because she has served so long and so well. Ms: Rossman: Let's incorporate that invitation in the letter.

Dr. Moses: That's a good idea. She really deserves it. And perhaps we could request a commendation certificate to go with it.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-18): Be it resolved that the minutes of the Mental Health Board meeting of June 11, 1997, be approved as submitted. (Passed)

RESOLUTION (MHB-97-19): Be it resolved that the Mental Health Board send a letter to the State Department of Mental Health, through the California Mental Health Planning Council, stating that the Board has reviewed the Performance Contract for the City and County of San Francisco for fiscal year 1996/97. (Passed)

RESOLUTION (MHB-97-20): Be it resolved that the Mental Health Board send a letter to the State Department of Mental Health endorsing the request of the San Francisco Division of Mental Health for the renewal of the SAMHSA grant for fiscal year 1997/98. (Passed)

III. SMOKING POLICY FOR HOSPITAL PATIENTS

Dr. Moses called attention to Attachment C which provides background on the issue of smoking. Mr. Shipley announced that he had brought along the new policy memo on smoking from the Department of Psychiatry at San Francisco General Hospital, and copies were distributed.

Ms. Chartrand: After reading this and having some experience with this issue, I think it is a terrible travesty to force someone to go on the patch. Having a policy where people can go outside and smoke is important to people's sanity.

Dr. Moses: That's what the Executive Committee thought, too.

Ms. Rossman: As someone working on an inpatient unit, I can say that smoking is one of the things that people really look forward to. If we took that way we'd need twice as many staff. People on our unit are already agitated and angry. It seems to be an issue of patients rights.

Ms. Gilleran: One argument which is persuasive is that all medical treatment depends on a balance of negative effects and positive. With medications, the negative side effects have to be balanced with the positive effects of the medication. I understand that the nurses are in opposition to the second hand smoke. One option is to have a glassed in room where patients could be observed, but there would be no second hand smoke, like at the airport.

Ms. Rossman: At the VA Hospital we have one staff member with 12 patients. There is a camera for security, and the space is enclosed, but is open to the air. Most people coming into our unit smoke. And it's an infringement on their rights not to let them smoke. Nicotine is harder to kick than heroin.

Ms. Planck: And most people have been smoking for many more years than people generally use heroin.

Ms. Ruffin: Is the MHB proposal being considered just for 24-hour involuntary programs? The County has no-smoking legislation which covers all City buildings.

Ms. Rossman: For me it's just for involuntary programs. People are already stripped of certain rights. Even smoke breaks are timed, and people don't have a choice about when to take their breaks. People are already freaked out from being locked up, and then you take away the one thing that calms them down.

Ms. Ruffin: The proposal is swimming against the current of the popular position in terms of City legislation. We should think about how we want to present this and to whom.

Ms. Gilleran: You might want to ask the City Attorney to check on a case in San Mateo for a situation where an exception was made.

Dr. Beauford: My understanding is that this is just for locked wards. People in other buildings have the freedom to step outside and smoke. Ms: Rossman: What about the patio, it's locked, but is an open-air space. Mr. Shipley: We've been told that the problems are: 1) staff time taking people out to the patio, and 2) providing cigarettes for people.

Ms. Rossman: What I'd like to have clear in general is that with managed care we're losing the focus on the patient. For a lot of these people the cigarette is their mainstay. Maybe they need to have staff go out for 10 minutes every couple hours. In the long run you'll be saving on staff member's being hurt by people who are angry.

Ms. Burton: They're dictating again: You can't have cigarettes; you have to take the patch. This seems hostile. Ms. Planck: Forced withdrawal has not been shown to be effective with nicotine or any other drugs.

Dr. Shue: What about the Mental Health Rehabilitation Facility? Ms. Planck: They have a large open-air courtyard. Dr. Shue: It seems like this restrictive policy is just adding insult to injury. Ms. Rossman: Do they allow people to have coffee or caffeine? We don't give our patients caffeine. So they have that withdrawal. Mr. Shipley: They serve coffee during the day, but de-caf during the evening.

Mr. Schreiber: I used to be with Americorp and Swords. I agree with Alex. I think to take away people's smoking breaks, you're not going to help them.

Mr. Wise: I don't think people are in the hospital for punitive measures to be taken against them. The purpose is to help them get back out on their own, and this policy doesn't seem to help. I'm opposed to the idea of a glass room, it's like being in a fish bowl. Also it's therapeutic just to have the change of going outside for the break.

Mr. Kalman: I've never smoked in my life, but unfortunately my son does. When he was at Langley Porter, there was no smoking. He got a nicotine patch, but the doctor had to discontinue it because of the side effects. The doctor told me to bring him chewing tobacco, and my son didn't smoke for two weeks after he came back out. I think my son had the will to break the habit, but it's not easy. Maybe people should be given an alternative like chewing tobacco.

RESOLUTION (MHB-97-21): Be it resolved that the Mental Health Board send a letter to all hospitals with which DMS contracts for psychiatric inpatient services, including the following points: 1) that their patients have the right to smoke, and allowing them that right could decrease their stress levels, their psychiatric symptoms, and consequently, the length of their hospital stay; 2) smoking cessation patches, or chewing gum should be offered, especially for those who want to quit or who have smoking-related physical health problems, but the decision must be up to the client. Be it further resolved that a similar letter be sent to Jo Ruffin, Deputy Director of Mental Health Services, recommending that such accommodation be made a condition of contracting with DMS to provide psychiatric inpatient services. (Passed)

IV. MHB COMMITTEE REPORTS

Executive Committee

Dr. Moses called attention to Attachment D, a proposal by the Executive Committee for a Mental Health Board Retreat. He said that the Committee thought it would be a good idea to get together to share feelings and resolve some issues, and that guidelines would be followed to make the meeting productive.

Ms. Chartrand: I think this is a good idea. Corporations do it. It's imperative that we do this.

Ms. Planck: In the past we've done a full day retreat and have divided the day in half, one half on Board issues and one half on mental health issues. Perhaps we could invite Jo to come give us an overview of the system. Ms. Ruffin: I'd be happy to come give an overview. That fits in with my offer to provide the Board with an orientation.

Mr. Shipley: I serve on many Boards and every one I serve on has 1-2 retreats per year to help solidify the Board, to help plan for the year, to help us remember why we're there, and to get to know other people who serve on the Board.

Ms. Planck: And maybe have a little fun, too.

Mr. Shipley: Yes, we need to have some fun as a Board, too.

Ms. Chartrand: I'd like to recommend the first weekend in December.

RESOLUTION (MHB-97-22): Be it resolved that the Mental Health Board hold a one-day Board retreat on Saturday, December 6, 1997. (Passed)

Dr. Moses added that suggestions for a meeting place could be given to Mary Sue, and that suggestions for the program for the retreat should be submitted in writing to the Executive Committee or in person at an Executive Committee meeting.

Dr. Moses: We have so many things coming up and we'll be having members out of town during August, how does the Board feel about canceling the August Board meeting?

RESOLUTION (MHB-97-23): Be it resolved that the Mental Health Board cancel its regular monthly Board meeting scheduled for August 13, 1997. (Passed)

Children's Committee
No report.

Program and Services Committee
Ms. Gilleran: I'm so happy to be Chair of this committee. It's such a great committee, I'm proud to work with them. It's a good, strong committee, with differing opinions, but people work together.

We're preparing for program reviews. This is where we interview people in programs to find out how they feel about the services they're getting. We've come up with a list of 23 programs we want to review, including: the 3 new Single Point of Responsibility Programs, the Mental Health Rehabilitation Facility, Patients Rights Advocacy Services, six of the Conard facilities—Washburn, Jackson, Aarti, Dolores, El Dorado, Midori—, Episcopal Service Center, McAuley Adolescent Day Treatment, Bayview Clubhouse, STEP, Office of Self Help, Community Vocational Services, Mobile Crisis Unit, and the inpatient wards at San Francisco General Hospital.

Reviews are not just done because there are problems with a program; they're done for lots of reasons.

MHB members and others who have been trained will go out singly or in pairs to interview clients and staff, following a questionnaire.

Ms. Planck: We let clients know that the interviews are voluntary and confidential. We send signs for the program to post ahead of time to let people know we're coming.

Dr. Moses: I did a site visit last year. Guess who was nervous? The staff. The clients were really friendly and glad to talk to me.

Ms. Planck: There's nothing like going out there and talking to people to know what's going on. Dr. Moses: Us going out to talk to them is good therapy for the clients. Ms. Planck: And a good education for us. Ms. Gilleran: And it makes you feel like you really are on the Mental Health Board.

Ms. Ruffin: I appreciate the list you've picked. It used to be that you'd review every program and staff looked forward to it. Now you just do selective reviews and they miss you. I'd also like to suggest a review of the new South of Market Clinic, given the issues they have been going through. Ms. Gilleran: Yes, that's a good idea.

Public Relations
It was decided to hold off on the discussion of the Speaker's Bureau (Attachment E) until Ms. Leib returns from her leave of absence.

Mr. Shipley: Along the lines of the Speaker's Bureau and making connections, I went to 2 conferences recently. One was put on by Concordia, and it was focusing on the latino community. The other was focusing on the Asian American community. When I spoke up as an MHB member, half of the people there didn't even know there was a Mental Health Board. I believe in being an advocate and letting people know that we are here to advocate for them. There's only been so much done in the past. I think a Speaker's Bureau could be good if people are willing to do it. We all represent different constituencies and populations.

Consumer/Family Member Task Force
Mr. Leoni: We spent time working with Rinna Flohr and others on the consumer handbook for when outpatient managed care starts. The implementation plan has come back from the State, and they are asking for more detail on consumer/family member input on quality management. That will be our main focus at our next meeting.

Community Advisory Board
Mr. Shipley: We had a report about PES calling a diversion recently, the first time they've ever done this. They had too many people at PES and had to find space in other hospitals. Although this was the first time for a diversion, it went well. There were a few little bumps, but otherwise it worked well. We also had a long presentation on the smoking policy. We nominated new officers. I was nominated for Chair and Ron Persons was nominated for Vice Chair.

California Association of Local Mental Health Boards
Mr. Shipley: I'd like to request that the MHB support the CALMHB by paying the $300 annual voluntary dues. The dues help with mailings, phone bills, copying, and help pay for room accommodations and transportation to state meetings. CALMHB works closely with the California Mental Health Planning Council and the Mental Health Directors Association to advocate for legislation like AB 1100 and AB 486. CALMHB is made up of all the Mental Health Boards in California. There are 5 regions. I am the consumer representative for the Bay Area region as well as the SF MHB representative to the Association. It's a place where you work side by side with other organizations to get things done.

Ms. Ruffin: I think the Board having an official representative to CALMHB and Mickey being chosen as that representative is a win-win situation. Under managed care, there will be many issues where we will want to be involved and have a consumer advocacy group. I think DMS would be open to considering a request to help financially with the dues.

There was a consensus that the MHB recommend to the SFMHEF Board of Directors that the $300 annual dues be paid, and that the SFMHEF Board talk with Ms. Ruffin about the possibility of financial help on this.

DMS Leadership Work Group
Mr. Leoni: One of the issues that has come up has to do with the Single Point of Responsibility Programs. We're moving people from the locked facilities into the community in order to pay for the SPR's. DMS is eliminating 80 locked facility beds. That means we have to get people out of the locked facilities and into SPR's. The SPR's are voluntary. But if a person has a conservator the conservator can sign off and register the person for the SPR. We want people in the SPR's who are voluntary. This new policy has introduced about 5% of participants into the SPR's who are told by their conservators to go there.

Ms. Ruffin: There are reasons why this occurred. The clients in the locked facilities are involuntary. Some clients who could do well at the SPR are not being referred by staff. This policy allows the conservator to give the person a chance to try it out. But once a person is at an SPR then it has to be voluntary participation.

DMS Managed Care Committee
Mr. Leoni: This committee is open to everyone, and meets at 9:30 a.m. on the third Thursday of every month. There is a new augmentation in the budget to create 65 new Board & Care slots, which are desperately needed. If we are not successful at reducing 80 locked facility slots, then the money for the SPR's will have to come from somewhere, like an across the board cut to community programs. We have a commitment to moving clients to the least restrictive level of care.

DMS Quality Policy Committee
Dr. Moses asked for someone to replace him as the representative to the Quality Policy Committee. Ms. Rossman volunteered.

DMS Pharmacy and Therapeutics Committee
This is a new committee. Ms. Gilleran will be attending for the MHB.

DMS Committee on a Culturally-Competent System of Care
Dr. Moses asked for an MHB representative to this committee. Dr. Beauford said he would consider it.

V. REPORT OF THE DEPUTY DIRECTOR
Jo Ruffin: I would like to join the Board in appreciating Norma Block. I worked with her for the last year and a half, and it was a particularly good working experience.

Dr. Peter Forster is our new Medical Director. He will be starting full time at the end of July. He was previously Medical Director at PES, so he is very familiar with the San Francisco system. Then he was Director of the John George Pavilion in Alameda County. He will be helping to oversee Pharmacy and Therapeutics.

We recently had to call for a diversion from PES. It was the first time, but we hope it will be the last time. This is not a good way for us or PES to do business. So we are reviewing the flow of clients into PES, so clients don't have to go on diversion.

We got the Implementation Plan back from the State. There are three areas where they wanted additional information:

1. The quality management plan.
2. Claims processing.
3. Cultural competency. The cultural competency guidelines have not been sent out by the State yet, but Tina Yee from DMS is on the committee which is developing those guidelines and we have prepared our plan so that we meet the maximum of what the guidelines might request, so we should have no problem in meeting the State's requirements in this area.

We are having to move at breakneck speed on our consumer and provider manuals. We probably will ask the State for a delay of implementation to January 1, 1998.

I told you a couple months ago about the proposal for dual diagnosis funding that the courier got to Sacramento after the deadline and thus we were disqualified. The State has found another source of money through Blue Cross as it goes to being a nonprofit and is providing funds for community initiatives. Our proposal has been selected as one to possibly be funded from that money. We were told that if we had made the deadline we would have been #6 among all the proposals submitted.

The Foster Care Proposal developed by the MHB and DMS is not dead. Under the new community health program, the foster care population is one which will be a focus population and we'll probably be incorporating parts of the proposal into our plans.

The budget went through. There was a request for $1 million in salary savings by the Budget Analyst, but the Board of Supervisors overruled that. There was no COLA, but the Board did add $1 million department wide in incentive initiatives. The Office of Consumer Affairs is in the budget and approved. But we are not allowed to fill the positions until the end of the first quarter.

VI. PUBLIC COMMENT

Mr. Wise: I am saddened by the departure of Sandra Hernández. I felt personally connected to her. I felt she had our best interests at heart and felt such optimism with her as the Director of Health. I would hope she could come to the Board sometime and share her expertise with us.

There was a consensus to send Dr. Hernández a letter from the Board.

Mr. Leoni: It's important to remember that even though Sandra Hernández is leaving the Department of Public Health she's not leaving public health. She'll stay on the Blue Ribbon Committee, and so it will be important to stay in contact with her. And she continue to serve on President Clinton's Committee on healthcare.

Ms. Chartrand: I just wanted to let you know that I've been doing lots of PR on behalf of the Board that maybe people don't know about. Mayor Brown declared July 1st April Martin Chartrand Day in San Francisco.

Mr. Shipley: It might be good to let the Chair know about PR work that people are doing so the whole Board can be informed. Ms. Gilleran: When we discuss the Speaker's Bureau, perhaps we could set up a clearinghouse system for that information.

Dr. Moses: The Executive Committee was thinking to have a potluck sometime instead of having our meetings be all work.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:20 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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8/13/97
canceled

The Mental Health Board meeting scheduled for August 13, 1997, has been CANCELED

The next meeting of the Mental Health Board will be
Wednesday, September 10, 1997.
An agenda for that meeting will be sent out
at the beginning of September.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD

Wednesday, September 10, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

10 min. **I. CALL TO ORDER, INTRODUCTIONS**

10 min. **II. CONSENT CALENDAR**
- Approval of July Minutes
- Protection & Advocacy Recommendations re: Abuse of Patients at Napa State Hospital (See Attachment A)
- C/FMTF Recommendation re: Credentialing & Alternative Treatment Methods
- PATH Grant: Ratification of Action Taken by Executive Committee

45 min. **III. SPECIAL PRESENTATION: Program Reviews**
- Description, Explanations (See Attachment B)
- Demonstration

30 min. **IV. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's Committee/Public Relations
- Program & Services Committee
- Consumer/Family Member Task Force
- SFGH CAB
- MHB Representatives to DMS Committees

15 min. **V. REPORT OF THE DEPUTY DIRECTOR/DMS REPORT**
(Systems of Care Director Collins Munns will be Reporting for Jo Ruffin who will be attending Mental Health Directors' Meeting)

10 min. **VI. PUBLIC COMMENT PERIOD**
Members of the Public will have up to 3 minutes to comment on any issue within the MHB's purview, except for issues on which they have already commented.

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The wheelchair entrance to 1380 Howard is on Grace Street, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Street off Howard.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:30 through the end of the Mental Health Board meeting, to let people into the building.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES

Wednesday, September 10, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Toye Moses, Ph.D., M.P.H. (Acting Chair); Jim E. Beauford, Ph.D.; Darwin Dias; Peggy Gilleran, J.D.; Lois A. Jones; Mickey Shipley; Sylvia Shue, Ed.D., Lora Traveler, M.A.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; April Martin Chartrand; Maria Leib; Alex Rossman, M.S.W.; Paula Wilson.

BOARD MEMBERS ABSENT: Anita Burton.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni

OTHERS PRESENT: Chester Villalba; Collins R. Munns (CMHS); Sai-Ling Chan-Sew (CMHS); Sherry Barto (CMHS); David Smith; Mike Wise (Residential Care Task Force); Dwight D. Darkes (Consumer); Mary Sue Planck (MHB); Rich Snowdon (MHB Staff).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Dr. Moses, Acting Chair, at 6:37 p.m.
Dr. Moses then introduced Chester Villalba who is in the process of being appointed to the Mental Health Board by the full Board of Supervisors.

Mr. Villalba then introduced himself as follows: I've been a resident of San Francisco for only three years. We lived in Silicon Valley and when it was time to retire, we decided not to go out to pasture, but to move to the city and enjoy all the things that go on here.

I'm a Family Member. I have a son who is diagnosed with schizophrenia. It was a surprise and not a surprise when we found this out, since I've been a mental health professional all my life. One doesn't know what will be offered to us in this life. I hope to use my professional expertise to help in the work of the Board, but mostly I will be using my personal experience as a Family Member. I'm pleased to get acquainted with all of you.

Ms. Planck added: Chet is an expert evaluator. He also just received a national award as an outstanding Peer Reviewer for the National Council of Accreditation for Family and

Children's Services and Mental Health. Mr. Villalba replied that he had been surprised to receive the award, and had been in New York last month to receive it at a dinner in front of the Statue of Liberty. He said that he had been a peer reviewer for 15-18 years, and had served as the Executive Director of a Family Service Agency in Silicon Valley.

The rest of the members of the Board then introduced themselves.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-24): Be it resolved that the minutes of the Mental Health Board meeting of July 9, 1997, be approved as submitted. (Passed)

RESOLUTION (MHB-97-25): Be it resolved that the Mental Health Board write a letter to Stephen W. Mayberg, Ph.D., Director of the California Department of Mental Health, with a copy to John Rodriguez of the Division of State Hospitals, saying that the Board has received the document from Protection and Advocacy entitled "Report on Alleged Abuse of Patients at Napa State Hospital," and that the Mental Health Board support Protection and Advocacy's recommendations as follows:

1. The State Department of Mental Health should be accountable and ensure that all of its hospitals fully implement a proactive systems approach to abuse-related special incidents.

2. Napa State Hospital and the California Department of Mental Health should take prompt action to ensure that allegations of staff-to-resident abuse are thoroughly and competently investigated and appropriate follow-up action taken. (Passed)

RESOLUTION (MHB-97-26): Be it resolved that the Mental Health Board write a letter to Jo Ruffin, asking that the Community Mental Health System, in its selection and credentialing of providers, take into consideration alternative methods of treatment and make an extra effort to resolve any issues that may arise, including liability, and not exclude such providers on the grounds of a technicality. (Passed)

RESOLUTION (MHB-97-27): Be it resolved that the Mental Health Board ratify the action taken by the Executive Committee in stating that it has reviewed and supports the Community Mental Health System, request for the renewal of the federal PATH grant for 1997. (Passed)

V. DEPUTY DIRECTOR'S REPORT (Part 1) (taken early on the agenda)

Sai-Ling Chan-Sew reported as follows on specific questions the Board had asked about Children's Services:

1. Family Mosaic Project
Family Mosaic is an intensive case management program for seriously emotionally disturbed children. It's in its 7th year of operation and is going very well. Recently the Director resigned so we are recruiting a new director.

A team of 5 auditors began a review of Family Mosaic yesterday. So far we are hearing they are quite impressed with the work we are doing and with the difficulties of the children who are being served.

I'm currently acting as Interim Director of Family Mosaic and am spending a couple days a week at the program. We also have an Advisory Committee for the Project and both Toye and Maria from your Board are working with that Committee.

2. Barrier Elimination Grant
We've received a special grant from the State Department of Mental Health to expand our system of care for children. In the County of San Francisco, we have lots of services , but one of our biggest problems is fragmentation. We want to bring everyone to the table to see how we can coordinate services and fund more services. So far we've included Juvenile Probation, the Mayor's Office of Children, Youth and Their Families, the School District, parents, community based organizations, and the Children's Mental Health Policy Board. We are just starting the planning process.

3. Federal Block Grant
President Clinton signed a bill to provide coverage for uninsured children. There is an annual appropriation of $855 million for children in California, so this is quite a significant amount of money. However, there has been a lot of lobbying going on behind the scenes already. There will only be two hearings on this funding, and they are happening with very short notification, and the vote will be held in the legislature this coming Friday, which is the last day for a bill to be passed before the legislature recesses.

Governor Wilson does not want the funds to go through Medi-Cal or through the County bureaucracies. He wants a private company to handle the money. We are still trying to clarify what the mental health coverage will be under this bill, but it's still fuzzy. Federal law says mental health coverage has to be provided at at least 75% of whatever benchmark is chosen. Jo Ruffin is trying to get more information.

Ms. Traveler: Who's monitoring what the Governor is doing with that mental health money? Ms. Chan-Sew: Children Now and the professional organizations are all working on that. But there has been a very short time frame. Ms. Traveler: How much is the funding for the Barrier Elimination Grant? Ms. Chan-Sew: $300,000. Ms. Traveler: Will there be an MHB representative on the policy board for the grant? I certainly hope so. Ms. Chan-Sew: It's open.

Ms. Jones: I'm on the statewide technical assistance panel for the Barrier Elimination Grant. We are concerned that parents are genuinely included, and we are concerned about cross system training. I think there's already been some work that's been done that we can build on. We can take these issues up in the Children's Committee.

Ms. Chan-Sew: We not only want to have parents in on the planning, but we want to hire parents to be part of the implementation. We have written that into the grant.

Dr. Beauford: Even though the benchmark has been set, that's based on an adult model of 20 visits, and that has to be expanded for children. HMO's are finding that that's not enough. Mr. Shipley: It's also not enough for a lot of adults.

Dr. Moses to Ms. Chan-Sew: I want to commend you on the work you are doing full time as Director of Children's Services and running the Family Mosaic Project at the same time. I will ask the MHB staff to relay this message to Jo Ruffin.

III. SPECIAL PRESENTATION: Program Review
Ms. Gilleran introduced the special presentation prepared by the Program and Services Committee.

The presentation began with four role plays of different program review situations.

Scene 1, Interview with a difficult program director
Ms. Gilleran played the MHB program reviewer interviewing "Dr. Feelgood" played by Darwin Dias. She checked for the Patients Rights Poster and the Grievance Procedure Poster. She noted the Director's bad attitude, but did not confront it. Then she insisted that the client interviews be done in private without the Director sitting in to "help."

Scene 2, Client interview done the right way.
Dr. Shue played the client and Mr. Shipley was the MHB reviewer. He introduced himself, and explained how the review worked, that it is confidential, and why the review was important. He then asked a series of questions finding out what the client liked about the program, and what she wanted to see changed or done better. He demonstrated excellent active listening.

Scene 3, Interview with an excellent program director
Ms. Gilleran played the MHB reviewer and Ms. Traveler played the Program Director. The Director was welcoming and cooperative, answering the reviewer's questions in detail. She was very forthright about the challenges the program was facing and still needed help in solving.

Scene 4, How not to do a client interview

Horns were passed out to Board Members and members of the audience to be blown whenever they saw something wrong take place. Dr. Moses played an upset and very articulate client, and Mr. Shipley played the reviewer.

The reviewer come into the interview room and said that he was there to do an investigation to decide if he would shut the program down. Horns sounded. Comments included: A review is not an investigation, and the MHB has no authority whatsoever to shut down a program.

The client complained about the medications he was taking. The reviewer said that all those medications were terrible medications and that he'd make a few calls and get them discontinued. Horns sounded. Comments included: Reviewers should note complaints, but not pass judgment, and not promise to make changes.

The client then complained about the food at the program and said it had poison in it. The reviewer said, "That can't be true, you're obviously delusional." Horns sounded. Comments included: Reviewers should note client comments, not pass judgment on the clients, or do therapy with them.

The client continued discussing concerns and complaints, but the reviewer was staring off into space and then cleaning his glasses. Horns sounded. Comments included: Reviewers should be giving the clients their undivided attention and should be treating clients at all times with full respect.

The client continued talking, and the reviewer interrupted saying, "Could you speed this up, I have another appointment." Horns sounded. Comments included: Set aside enough time to do the review so that client interviews do not need to be rushed.

Ms. Gilleran then introduced the second part of the presentation: This has been a lot of fun, but this is serious stuff, too. Program reviews go right to the heart of why we are here, why we are members of the MHB. We have a good number of programs on our list to review, and we all have to bite the bullet and make time in our schedules to do them.

She then reviewed the guidelines and how-to of program reviews as follows:

PROGRAM REVIEW GUIDELINES

WHAT IS THE PURPOSE OF THE REVIEW?

Simply speaking, programs are reviewed by Mental Health Administration and by the Mental Health Board to see if they are doing a good job. DMS is interested in how many clients they see, whether records are kept properly and if the program is meeting the terms of its contract, or if they are following the City's and Division's rules and procedures. The MHB and its citizen volunteers review programs for two reasons. First, and most importantly, to learn from the clients what they think of the

services and whether they are satisfied with the program. Secondly, through talking to the clients and interviews with the staff, we learn more about San Francisco's services; doing the reviews helps to put a human face on the reports and statistics we hear at meetings. For the last several years, these two parts of the review (DMS and MHB) have been conducted separately.

WHAT ARE THE RESULTS?
After the review, you will write a brief report and rate the program. These reports and ratings will be read by Administration, the Health Commission, and any member of the public who asks to see them. Programs rated less than satisfactory in any area are required to submit a plan for correction, or risk their future funding. Serious problems in the area of client care may be addressed sooner, by DMS and the MHB. Many changes in the way services are delivered can be traced back to recommendations from program reviews.

SHOULD YOU BE DOING THIS REVIEW?
Generally speaking, you should not sign up to review a program with which you have, or have had, personal involvement. This includes your having worked there or a close family member or friend working there now. You should also not review a program where you have been a client or a volunteer, whether your experience was positive or negative. Even if you're sure you can be objective, it doesn't look good, and could cast doubt on the validity of the entire review.

and, finally.....

WHAT THE REVIEW IS NOT
In "real life" you may be a consumer, an advocate, a parent, or a doctor; but at the review you are ***a member of the public, representing the MHB,*** on behalf of all present and future clients of the program. You are not there to advocate for, diagnose or counsel individual clients. Do not, for example, promise to help get their medication changed. If a client thinks his or her medication is not right, include that in your report, even if it seems to you that the medication is appropriate. Do not edit their comments because they seem paranoid or "unreasonable". You are there to report what they think and feel, not to judge, agree or disagree. If clients feel their rights are being violated, don't take a position on that. You could tell them about PRAS (Patients Rights Advocacy Services) if they don't know about it, but more importantly, note in the review that clients don't seem to know about PRAS - then look to see if the required sign with patients' rights information is posted conspicuously and ask if that information is given to clients upon intake, or discussed in group or with their therapist, etc.

In the staff interview, remember that you are not conducting an "investigation" and that this is not the place to air your differences with program philosophy or practices. You are there to get information. That information may later be used by

the MHB to recommend changes in philosophy or practices, but the program review is not the place to do it.

"HOW TO"
A STEP-BY-STEP GUIDE

1. Sign up. Mary Sue or Rich will know which reviews are open. Be sure to allow yourself enough time - plan to spend most of a morning or afternoon at the program.

2. You will receive a packet containing a copy of the program's latest review, a client questionnaire, another one for staff, and a blank form (called Monitoring Checklist, Category 11) on which to submit your report. Pay attention to any problems or recommendations in the last review; you will want to check on their progress.

3. The client interviews are the most important part of your assignment, as this is often the only chance clients get a chance to talk about their treatment in an anonymous, no-pressure setting. See attached Client Interview. A Notice to Clients has been sent to the program, along with a Letter to Clients which explains the process in more detail. Directors have been asked to post the notice and distribute the letters. If very few clients show up, check to see how visible the notice is, and ask if clients received the letter. Note that no program that does not make a sincere effort to allow clients to be involved in the review can receive a rating higher than "2" in Category 11.

4. Familiarize yourself with the client and staff questionnaires.

5. If problems do arise during your visit, save them and report to the MHB office after you have left the site. Do not make an issue of it at the time.

6. USING THE FORM (MONITORING CHECKLIST, Category 11 - Advisory Board Review)
   A. Ratings: There are four possible ratings, from a low of "1" to a high of "4". The form has four areas to be rated based on the client interviews and five based on the staff interviews. They are described on the second page of the form. For example: you interview seven clients. Four of them say they were involved in their treatment plans, one says she was not and two are not sure. You'd rate that area a "3" since most responded positively and only one was completely negative. See also attached Sample **Monitoring Checklist Category 11 - Advisory Board Review**

   B. Recommendations: With ratings of 2 or 1, you need to include a recommendation for improvement. With a rating of 3, you may still want to recommend improvement; though 3 is acceptable, it isn't perfect. In the above

example, you might recommend that staff spend more time explaining the forms and going over the treatment plan more than once, especially if clients were heavily medicated the first time it was done.

Ms. Jones: There another significant thing to add. I bowed out of doing program reviews about 3 years ago because part of my job is being a parent advocate, so it's not reasonable for me to review programs I'm advocating with. Ms. Planck: Maybe you could review programs in the adult services.

Ms. Jones also raised the question of cultural differences and what to write down during the client interviews. Dr. Shue responded: When I do reviews I write down what the client says verbatim. Dr. Beauford added: It's very important to be very objective in writing your report. The Director may say things are wonderful and the clients may say things are awful, and the temptation is to make assumptions, but it's important to write down a report as objectively as possible.

Dr. Moses: One reason I played that role in the 4th scene as a foreigner is because you might run into foreigners doing interviews. In my country if you say you're mad, they put you in the mental health institution, but here it just means you're upset.

Dr. Shue: Every family coming from another country is going to bring part of their culture with them. It's important to write down notes verbatim.

Ms. Planck: We are doing random interviews, not a scientific survey. What we are doing is more like taking snapshots.

Ms. Gilleran: Often you do get the people who have something to complain about and who hope you can do something about it.

Mr. Shipley: I've never done a review before. Do you go on your own or as part of a team. Ms. Planck: Either is possible. We like to have new reviewers go out as part of a team of two. Also we send a team out to the bigger programs where we know we will probably have many clients who want to be interviewed. Years ago the reviewers from CMHS and the MHB went out on a team together, but it was much harder to coordinate scheduling that way, so now we schedule these two different parts of the review separately.

Mr. Wise: Will the review also be an evaluation with a point system to rate the program? Ms. Planck: Yes. Mr. Wise: I see a problem with that. The reviewer is not supposed to be too familiar with the program and go in as blind as possible. But then you are evaluating a program you really have no knowledge of. And the staff won't point out the problems. The clients may say everything is fine or everything is terrible, but you have no frame of reference to make a judgment about what they are doing right or wrong.

Ms. Gilleran: I have found staff expressed themselves frankly because most of the staff I've talked to were very dedicated people and I don't know if they talked about all the problems, but they did talk about problems and concerns.

Ms. Planck: These interviews are not intended to be scientific, but valuable information is picked up which makes them very worthwhile to do.

Ms. Traveler: We do have a frame of reference—our experience in the field of mental health. That gives us a good frame of reference. You don't have to have every ounce of information about a program, but you have a frame of reference coming from your experience and area of expertise.

Dr. Shue: We will also have the past review to refer to. If there are negative issues, we may chose to focus on those. We have a protocol which we follow, so people are not just going off on their own asking questions.

Dr. Moses: I'd like to commend Peggy on her report. When I did my first review, I was nervous as I arrived, but once I opened the door and saw the clients and staff my confidence come back. The review was a therapeutic experience for the clients.

Then Mr. Leoni reviewed the following points about interviewing clients:

THE CLIENT INTERVIEW

1. Conduct Interview *in private.* No program staff, volunteers, people from DMS, etc. are to sit in or "help". Possible exception: when there are two community members present and client agrees to talk to both , or when one is present to serve as a translator.

2. Make eye contact.

3. Treat client with respect.

4. Introduce yourself and identify yourself as being from the Mental Health Board, the Consumer Task Force or the SFGH CAB, as appropriate. Make it clear you are a community volunteer and do not work for Mental Health Services. If you are a mental health consumer, you may want to say so at this point.

5. Explain the purpose of the review and how the answers will be used. Make sure clients know that their opinions will be used but you will not be using their name.

6. Emphasize that their participation is voluntary; it is not part of their treatment and will not affect their discharge date, etc. They may decline to participate at all, or may choose to fill out the questionnaire on their own and mail it in. Be sure they know where to send it and have a stamped or franked (City) envelope to use.

7. Give an estimate of how long the interview will take. (Usually no more than half an hour.)

8. Ask how they learned about the program review - was a Notice to Clients posted, did they hear about it from a friend, was it mentioned in Group or at mealtime?

Then Ms. Barto passed out the Summary Report Form and discussed how the information collected during a review is used: Summary scores are recorded for the following areas: Program Performance, Program Compliance, and Client Satisfaction. The team leader of the review scores all areas. The Report is then signed by the author of the Report, a representative of CMHS, and the representative of the program being reviewed. If there is an area where there is a big problem, the program has to write a plan of correction before the Report is accepted.

The Summary Report goes to the Health Commission and they are always very interested in the reviews. This is also a public document. Anytime people want to request a copy of the whole report they can get a copy. It can be up to 20 pages long.

I recommend being as brief as possible in writing your report, and I also recommend writing it as soon after your interviews as possible while it is still fresh in your mind.

Davis Jah and Associates will do the site visits for CMHS. They don't get paid until the reports are in, which includes your part of the report. The final deadline is November 21st, so there is some urgency. We would like to see most of the reviews happen in October.

I've been very impressed by the ratings done by the Board over the years. They have been very fair. I've never seen a Board member rate programs too high, or be out to get a program. If a program has been rated less than satisfactory, it's always been because there were genuine concerns that we needed to look into.

IV. MHB COMMITTEE REPORTS

Executive Committee

Ms. Planck reported for the Executive Committee: There have been two Executive Committee meetings since the last Board meeting since there was no Board meeting in August. In July the Executive Committee recommended approval of the PATH Grant and recommended support of the Protection and Advocacy recommendations, both of which are included in tonight's Attachment A.

We will be following up on the services offered mental health consumers by the Recreation and Park Department. We will also be following up on housing, including the housing in the Presidio.

We decided with regard to meeting minutes, to use the system used by the Board of Supervisors and the Health Commission.

With regard to AB 1100, at our recommendation, the City and County of San Francisco officially endorsed this bill for parity for mental health, and in their letter of endorsement detailed the two concerns we had about the legislation: a) that providers of services not be limited to psychiatrists only, and 2) that the medications and illnesses covered not be limited to just those listed in the legislation.

Children's Committee
Ms. Jones reported: We're moving ahead on setting a date in January or February for a Mini Summit on Transition Services. We will also be looking at the Barrier Elimination Grant to see that parents are participating in a meaningful way.

Consumer/Family Member Task Force
Mr. Leoni reviewed the Task Force item in Attachment A.

Community Advisory Board
Mr. Shipley announced that he had been elected Chair of the CAB, and that Ron Persons had been elected Vice Chair. Dr. Moses: Congratulations Mickey. We know you can handle it very well. We've seen you in action.

DMS Quality Policy Committee
Mr. Leoni: The highlight of the meeting was the concern about the loss of client property. Some years ago a proposal was developed by the Mental Health Association. The idea was to provide help to clients when they go into the hospital to make sure that their rent was being paid, that their apartment was locked up, that any pets they had were looked after. Interest is now being shown by the SFGH Foundation in funding part of such a proposal.

V. REPORT OF THE DEPUTY DIRECTOR (Part 2)

Mr. Munns reported for Jo Ruffin who was attending a meeting of the State Mental Health Directors Association: Thank you for the commendation you gave Sai-Ling Chan-Sew. She's one of our hardest working directors. She's doing more than two jobs right now until we can get a new director for the Family Mosaic Project.

1. HCFA, the federal Health Care Finance Administration, has approved a waiver for California for outpatient consolidation. Without that waiver, consolidation could not have moved forward. It's been a long process getting it approved. We expect to move forward with consolidation in San Francisco on January 1, 1998.

2. We're making progress on the Access project which is under the direction of Dr. Peter Forster. Space had been found on the second floor in this building to house the project. It is being co-located with the Mobile Crisis Unit. The 800# has been reserved

and lines are being established in this building, the computer and some software has been purchased and additional software development is being contracted out.

We are having some difficulty with some of the community programs which may be moving to new sites in the next year. It is a significant expense to install the Access hardware and software at each site. But I believe we can solve the problem.

We hope to be operational in December, so we can work out the bugs in the system before January 1st. Access is now hiring staff. It might be timely if you wish to have Peter come and give the Board a progress report on Access at your November meeting. He is the new Medical Director and is a forthright and excellent person.

3. We are continuing to make progress with the development of the Provider Network. An initial draft report has been prepared. More work needs to be done on how we're going to take too little money and serve a much larger population. Consultants are working on this. You could have a report made to the Board on the Provider Network in October, if you wish.

4. There are union organizing efforts going on at Westside. The Department takes a strictly neutral position in this kind of situation. We cannot support or oppose unionizing nor should we. Our concern is that there be no disruption of services. At this point there is no imminent threat of service disruption.

Dr. Moses: A couple meetings ago we had a presentation on acupuncture. Could you let Jo know not to forget our request for funding for acupuncture in preparing the budget for next year?

VI. PUBLIC COMMENT

Mr. Adamek: Spiritmenders has moved to a new site. I have the honor of succeeding Darwin Dias as President of the Board of Directors.

Dr. Moses: I want to thank all the Board members for your support over the past two months. I will be stepping down as Acting Chair, since our Vice President will be back in October.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:35 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
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fax: (415) 255-3760

SPECIAL ANNOUNCEMENT

A quorum of the members of the Mental Health Board of San Francisco will be in attendance at a Farewell Dinner to honor former MHB Chair Norma Block at 7:30 p.m. on Friday, September 19, 1997, at Mike's Chinese Cuisine, 5145 Geary Street in San Francisco. No business will be conducted at this meeting and no resolutions will be voted on.

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MEETING OF THE FULL BOARD

Wednesday, October 8, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

5 min. **I. CALL TO ORDER, INTRODUCTIONS**

5 min. **II. CONSENT CALENDAR**
- Approval of September Minutes

10 min **III. VISIT WITH MEDICAL DIRECTOR**: Peter Forster, M.D. , Medical Director for CMHS, will be here to "meet and greet" MHB members. We will be working with him ; next month he will do a presentation on the Access Project, so it will help if we all know each other.

60 min **IV. SPECIAL PRESENTATION: City Attorney:** Paula Jesson, City Attorney for the Department of Public Health, will be present. The Executive Committee has allocated one hour for the following:
- Laws and Ordinances that apply to MHB.
- Board Member Questions and Answers.

15 min **V. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's Committee/Public Relations
- Program & Services Committee
- Consumer/Family Member Task Force
- SFGH CAB
- MHB Representatives to CMHS Committees

15 min **V. REPORT OF THE DEPUTY DIRECTOR/CMHS REPORT**

10 min **VI. PUBLIC COMMENT PERIOD**
Members of the Public will have up to 3 minutes to comment on any issue within the MHB's purview, except for issues on which they have already commented.

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

FOR MORE INFORMATION ON YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE OR TO REPORT A VIOLATION OF THE ORDINANCE, CONTACT THE SUNSHINE ORDINANCE TASK FORCE AT 554-6075.

MHB ACCESSIBLE MEETING POLICY

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The wheelchair entrance to 1380 Howard is on Grace Street, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Street off Howard.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:30 through the end of the Mental Health Board meeting, to let people into the building.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES
Wednesday, October 8, 1997, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Jim E. Beauford, Ph.D.; Anita Burton; April Martin Chartrand; Peggy Gilleran, J.D.; Lois A. Jones; Toye Moses, Ph.D., M.P.H.; Sylvia Shue, Ed.D., Chester Villalba.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Darwin Dias; Alex Rossman, M.S.W.; Gloria Samayoa; Mickey Shipley; Lora Traveler, M.A; Paula Wilson.

BOARD MEMBERS ABSENT: none

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni

OTHERS PRESENT: Paula Jesson (City Attorney's Office); Jo Ruffin (CMHS); Collins R. Munns (CMHS); Josephine McCreary (CMHS); Mike Wise (Residential Care Task Force); Dwight D. Darkes (Consumer); Emeric Kalman (Family Member); David Page (MCAFSC); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:42 p.m. Ms. Leib made the following remarks: I want to thank Toye for covering for me for the past couple or three months. I want to thank Mary Sue and Rich for all the work they do.

We have a couple things planned for this fall for our own education. Specifically, tonight, we're looking at our legal and constitutional responsibilities. We have these refreshers periodically.

We are also in the middle of one of the most important things we do—program reviews. These reviews are one of the few things required of us. Please sign up if you haven't already done so.

Coming up is our Retreat, another mandated thing. It's required. It will be held on Saturday, December 6th from 9-4. When I was a new member of the Board, a few months into my first term, I attended the Board Retreat and found it to be very helpful.

IV. SPECIAL PRESENTATION: CITY ATTORNEY (Item taken out of order.)
Ms. Leib introduced Paula Jesson, who made the following presentation: I work in the Health and Social Services Division of the City Attorney's Office. I primarily advise the Department of Public Health and have been doing this for about 10 years now. I'll be responding to the questions that were sent to me.

A. Requirement to tape-record meetings (for "Charter Boards"). Is the MHB considered a Charter Board? Does this requirement apply to us?

Ms. Jesson: Section 67.16(b) of the San Francisco Administrative Code states: "Each board and commission enumerated in the Charter shall tape record each regular and special meeting." Since the Mental Health Board is not enumerated in the Charter, it does not have this requirement.

B. Secret Ballots Prohibited: Does this also apply to committees, sub-committees and task forces? Is a role-call vote required, or is show-of-hands sufficient? Must each member's vote be recorded in the minutes?

Ms. Jesson: Section 4.104 of the San Francisco Charter states: "Unless otherwise provided in this Charter, each appointive board, commission, or other unit of government of the executive branch of the City and County shall: ...3. Keep a record of the proceedings of each regular or special meeting. Such record shall indicate how each member voted on each question."

It's not clear what "board, commission or other unit of government of the executive branch" includes. There's no ruling on how far it extends. The safest course of action is to comply. If there is a need for a variance, you can apply to us for a ruling.

From state law, the Brown Act includes in the term "legislative body" a lot more than just the Board of Supervisors, specifically: "Section 54952 (b) A commission, committee, board, or other body of a local agency, whether permanent or temporary, decision making or advisory, created by charter, ordinance, resolution or formal action of a legislative body. However, advisory committees, composed solely of the members of the legislative body which are less than a quorum of the legislative body, are not legislative bodies, except that standing committees of a legislative body, irrespective of their composition, which have a continuing subject matter jurisdiction, or a meeting schedule fixed by charter, ordinance, resolution, or formal action of a legislative body are legislative bodies for purposes of this chapter."

You were created by the Board of Supervisors so you are a legislative body. So when you turn around and create advisory groups or committees they also fall under this. As a practical matter most of your committees will be subject to the law.

Ms. Jones: Then the committees have to have records of votes taken. Ms. Jesson: Yes. Let's look at this further. State law says: "Section 54953(c) No legislative body shall take action by secret ballot, whether preliminary or final."

I don't know of anything that requires you to keep minutes, but I will follow up on this. The Charter says that each commission or board enumerated in the Charter has to keep minutes. But it doesn't say whether sub-committees have to have minutes. But they do have to be open. I'll follow up on this. The Brown Act says the public has the right to know what business has taken place. Without minutes it's hard for them to know.

C. Financial Disclosure Statement: *Members of some Boards are required to submit financial statements. The MHB does not pass legislation or get involved in business activities; do our members still have to do this? If so, what is required to be covered in such a statement?*

Ms. Jesson: State law requires every public official who participates in the making of governmental decisions to disclose their financial status. The City has gone Department by Department and each Department has made its own list of who has to report and different levels of reporting. The higher up the person is, the higher the level of reporting that's required. This is an administrative code. The MHB is not under the administrative code. I've asked if you should have a reporting responsibility and if you should be added to the ordinance. Let me tell you how they are going to analyze this. If you give advice, but every time decision makers take it, then you would be considered to have decision making powers.

We looked at your obligations under state law. Most of them are advisory, but at least one of them, may be sufficient to make you a decision maker: "SEC. 15.4-1(a)(4) Review and approve procedures used to ensure citizen and professional involvement at all stages of the planning process." So the person in the City Attorney's Office who is in charge of conflicts issues will look into this and advise you.

Mr. Villalba: What would be considered a conflict? Ms. Jesson: There are two kinds of conflicts. First, financial interest in the results of a decision. If you're an employee, if you know the decision will affect you financially, you can disclose and be allowed to abstain from that vote.

Ms. Ruffin: But the MHB doesn't have that kind of role in contract decisions. Ms. Jesson: As a practical matter this kind of conflict may never come up. The second area of conflict is the area of approving contracts where the rules are much stricter. Sometimes board and commission members are allowed to disclose and abstain; sometimes they have to either get rid of their financial interest or leave the board.

D. Removal of a member: *This is not very well covered in the MHB legislation, either State (Welfare & Institutions Code) or City (S.F. Administrative Code). There are provisions for removal of a member if his or her behavior can be shown to be disruptive to the business of the board, but there are no official standards. What would we have to document before making such a*

finding and forwarding it to the Board of Supervisors? How can we ensure or promote the desired action by the BOS? Similarly, the legislation provides that a member can be removed for missing a certain number of meetings. How would that be accomplished, i.e.: how would it work in practice?

Ms. Jesson: Section 15.4(d) of the San Francisco Administrative Code states: "A member shall be removed from office if he or she is absent for four meetings in one year, unless the Mental Health Board grants that person a leave of absence. The Board may grant leaves of absence for one or more meetings. Upon determining that a member has been absent for four meetings in a 12-month period and that no leave of absence had been granted for these meetings, the Board shall provide written notification to the Board of Supervisors. Upon receipt of the notification, the position shall be deemed vacant."

Ms. Jones: Then we need standards for granting a leave of absence.

Ms. Jesson: Further, Section 15.4(e) of the San Francisco Administrative Code states: "The Mental Health Board may recommend to the Board of Supervisors that a member be removed from the Board on the grounds that the member's conduct is seriously disruptive of the functioning of the Mental Health Board. Once the Mental Health Board makes such a recommendation, the Board of Supervisors may remove a member from the Mental Health Board if it determines that the member's conduct is seriously disruptive of the functioning of the Mental Health Board."

This is one of those situations that is very fact-specific. You would have to state in detail answers to the following kinds of questions: What is the person doing? What steps have been taken to resolve the problem? Why didn't those steps work? There is a fine line between when advocacy and argument becomes disruption.

Ms. Chartrand: Couldn't there be some guidelines about behavior? Otherwise it becomes very subjective. Ms. Jesson: There can be a disadvantage if you set parameters, and then someone finds another way to be disruptive that is not covered by your parameters. Instead of defining disruptive behavior, you might think of procedural guidelines. If it gets to the point where it comes to a vote, the resolution will have to be passed by the majority of the Board. Then that recommendation goes to the Board of Supervisors. They might see a 5-4 vote differently than an 8-1 vote.

Ms. Leib: God forbid that this should happen, but we wanted to be prepared in advance. Ms. Jones: I agree with the idea of taking this up at the retreat. This was a good idea to have this presentation, Toye.

E. <u>Use of the MHB name</u>: Examples of when it is or is not appropriate to cite membership on the MHB or hand out MHB business cards when making inquiries, issuing invitations, or talking to the public/the press.

Ms. Jesson: The basic rule we always tell everyone is that you don't want to mislead people into thinking you're speaking for the Board when you are only speaking as an individual. It's okay to identify yourself as a member of the MHB, saying: I am a member of the MHB, so I have lots of relevant experience, but right now I am only talking for myself.

Ms. Leib: Where is the line between speaking for Board and general advocacy?
Ms. Jesson: The question to ask is if you can find what you want to say in one of the Board positions. It's okay to say, "The Board has taken this position." But if the Board has not taken a position on a particular issue, then how could anyone speak for the Board on that issue? Ms. Leib: What about the use of stationery. Dr. Moses: The bottom line is that the use of MHB stationery is a no-no, right? Ms. Jesson: Yes.

Ms. Gilleran: I feel comfortable with the process being that anything written that is to be sent out, first be approved by the Executive Committee. Ms. Leib: That's how it stands now. Dr. Moses: It would be appropriate for the Board to come out with a policy to give to new members. Ms. Chartrand: I had some of the situations people are talking about. I am doing a lot with the press and I'm working on domestic violence. I mention that I am on the Board but say I'm speaking for myself. But you can't always guarantee that a reporter will follow that. So if we have a policy that would be helpful, to give to the reporter and for us to know how to handle such situations.

F. Rules regarding taking positions on issues or lobbying as a Board. What is the local law that says no San Francisco Board or Commission may take a position on legislation? Can you get us a copy of it or tell us where to find one? We run into problems with the State Organization of MHB's on this one, because one of their mandates to us is to analyze legislation that affects mental health and communicate our position on it to appropriate individuals or groups. We've done our best to comply with the State without violating the S.F. law, i.e., we communicate with the State Legislative Committee (sometimes Pat Dunn calls us for advice on mental health related legislation which can be incorporated into San Francisco's official position.)

Ms. Jesson: There are two parts to this: First, the City and County of San Francisco is one legal entity. All powers rest in the Board of Supervisors if not given to any other department or official. If we are talking about a position taken by the City on state or federal laws, the entity that can take that position is the Board of Supervisors. The Department of Public Health or the Fire Department does not have a position, only the City has a position. You can recommend to the Board of Supervisors that it take a position for the City on a particular issue or law.

Second, there are a series of cases where decisions have arisen mainly out of ballot initiatives. Public officials are not allowed to use City resources to go to the voters to recommend that they vote one way or another on an initiative. The cases say that the City and County of San Francisco can't put up a sign for or against an initiative. But that's different than you going to the Department of Public Health or the Board of Supervisors to give them. Ms. Planck: We currently go through Pat Dunn, who's the

legislative planner at the Health Department. Ms. Jesson: Cases recognize that part of the way departments function is to sometimes come up with legislation, as DPH did with lead abatement.

Ms. Ruffin: One place the Mental Health Board has been very effective is in testifying on legislation such as the site approval ordinance. This is appropriate because it is coming out of the Board of Supervisors and is coming back to the Board of Supervisors. Ms. Jesson: Yes, and that is specifically a responsibility of the Mental Health Board under the law.

G. Please address the Brown Act, the Sunshine Ordinance and other Open Meeting Laws which apply to the Mental Health Board.
Covered under item B above.

H. Public Records Legislation/Rules: Are Public Records laws covered under Brown or Sunshine? What do we need to know?

The San Francisco Sunshine Ordinance goes beyond the Brown Act. The requirement to make records public comes from the State Public Records Act. Any document a public official uses is a public record and you start with the assumption that a document is public. The exceptions include: medical records, personnel records, books you checked out of the library, negotiations for property, and attorney-client privilege. But otherwise if a document relates to your work here, even if it is "just notes," or "just a draft," or "just e-mail," you still have to be careful, you have your public hat on.

I. Conflict of Interest: What do we need to know? Since MHB members are prevented by State and Local legislation from working for the State Department of Mental Health, San Francisco's Division of Mental Health or one of its contract agencies, we've almost never had a member who had to abstain from voting because of having a connection with one of the programs. Less formally, we make it a practice, when doing Program Reviews, for example, of not asking anyone to review a program in which he or she has been a client, a close friend or family member of a client, or a staff member (paid or volunteer) at the program.
Covered under item C above.

Dr. Moses: Would it be proper with any policies we draw up, that you review them? Ms. Jesson: Yes, I'd be glad to do that. Ms. Ruffin: Does the Mental Health Board have a direct line to you or only through the Director of Mental Health? Ms. Jesson: As a matter of practice, we take questions from advisory bodies. If you're asking them to route requests through you, that's between the Division and the Board. I'd feel uncomfortable telling an advisory board that I can't answer their questions without the approval of the Director of the Department. Sometimes we'll tell an advisory board, though, that what they are asking about is really more a departmental issue.

Mr. Leoni: The Consumer/Family Member Task Force is constituted as a subcommittee of the Board, to sponsor certain kinds of citizen input. But membership is independent

of the Mental Health Board. We only have one member of the MHB right now. After attending the CTF for 3 meetings on their 4th meeting a person becomes a member and can vote. How close does that make the link to the Mental Health Board.

Ms. Jesson: It seems to me that there's no requirement to have overlap, and you have your own internal rules about voting rights. Ms. Planck: This is the group that the question about the secret ballot came from. Ms. Jesson: Where the secret ballot usually comes up is in members voting for officers. Ms. Leoni: We did written ballots, but the ballots were kept as a record and anyone could look at them. Ms. Jesson: Then it's not a secret ballot. Since the Consumer/Family Member Task Force was created by a resolution of this body, then it is under the same general requirements as the other committees.

VI. DEPUTY DIRECTOR'S REPORT (Part 1) (taken early on the agenda)
Ms. Leib introduced Josephine McCreary, Director of Provider Systems, to talk about the new Provider Network which is a key part of outpatient managed care. Ms. McCreary reported as follows: I'll be giving you a quick update on the Provider Network. State law requires that we offer the opportunity to all fee-for-service providers to work with us, so we've sent out invitations and information to a list of 500+ psychologists and psychiatrists. We've asked Foster Care to send out to another 200 packets to their providers.

We had an initial meeting during the 3rd week of September. Over 290 providers responded to us, but only 65 came to the meeting. We'll be having a second meeting in the 3rd week of October.

Of the total of 720 providers we sent invitations to, 263 asked for application. One hundred ninety-five said they currently had MediCal clients in treatment. One hundred sixty-five were individual providers and 40 were currently members of groups. We sent out the applications several weeks ago and 3 have been returned, and we've received 100 phone calls.

Ms. McCreary then handed out the draft of the rate sheet and continued: The State has not given us as much money as they spent on the same services last year, so the rates are not as high as we'd like them to be. We have reduced the total number of codes to 32 to make the system less confusing. The State has said that we are allowed to raise the rates, but not lower them. We've increased the rates for individual therapy, medication, and evaluation. We really want good evaluations, in order to set up effective treatment plans.

We are looking for groups of providers which are multi-disciplinary and multi-lingual. We are putting out Request for Proposals for groups to provide services. We're also asking for groups of physicians who can treat our clients in residential centers.

Mr. Villalba: Some of the rates are quite low compared to individual rates. Ms. McCreary: None of the counties could increase all their rates. We've gotten a 40% response rate when most counties are getting a 30% response, so there is interest in working with us despite the rates. Providers have till June of 1998 to return their applications, so there is still a lot of time.

Dr. Shue asked about evaluation of the providers. Ms. McCreary: The State has mandated that all credentials be verified by primary source. That means verifying degrees directly with the university and licenses directly with the licensing board, and finding out if there have been any penalties or suspensions.

Providers have till June to apply, but we are working to get them to return their applications by January. Ms. Ruffin: There will be a 6-month transition for existing clients in the fee-for-service system so we will have continuity of care. We'll verify them against the state list in the meantime, but at the end of the 6 months, we'll verify them through the credentialling system.

Ms. Planck: How does this affect alternative sources of care? Ms. McCreary: The State is very specific in their requirements. Providers have to be psychiatrists, psychologists, or master's level social workers or MFCC's.

Ms. Ruffin: The State never covered anyone but psychiatrists and psychologists in the past, except for foster care. So we are now opening to a broader provider pool, which will also be a way to get the diversity and language abilities we are looking for.

I'd like to give credit to Josephine and her staff for streamlining the provider codes. We will make payments out of this office and will be able to track payments. We think that when word gets out about this, we'll get more interest from providers in joining the Provider Network.

Ms. Chartrand: Have you considered providing sessions to help the providers complete the application. Ms. McCreary: We've only had information sessions so far, but that's a good idea.

Mr. Leoni handed out copies of the letter sent out to fee-for-service providers to give to current clients explaining the transition.

Dr. Beauford noted that the fees are particularly low. Ms. McCreary: Different counties have increased their rates in different ways, but the rates are still low compared to private fees. Dr. Beauford asked about the specific criteria in setting rates. Ms. McCreary: We looked at how much money we had, which was very limited.

Mr. Villalba: Will there be a directory of providers? Ms. McCreary: People will call an 800 Access number. This is important so we can check on eligibility, and then we can

match the person with a provider who will take MediCal, and match language needs right away.

II. CONSENT CALENDAR

RESOLUTION (MHB-97-28): Be it resolved that the minutes of the Mental Health Board meeting of September 10, 1997, be approved as submitted. (Passed)

III. VISIT WITH MEDICAL DIRECTOR

Postponed until November.

VI. DIRECTOR'S REPORT (Part 2) (taken early on the agenda)

Ms. Ruffin reported as follows: We're going through another reorganization. Under the Department of Public Health, there is now a Division of Public Health and a Community Health Network. The Division of Mental Health Services is now under the Community Health Network and has a new name: Community Mental Health Services. We used to be Community Mental Health Services years ago, so if you keep your stationery long enough, you'll be able to use it again.

We are planning to implement outpatient managed care on January 1, 1998. Peter Forster, our Medical Director, will be here next month to present on the Access Project.

I wanted to respond to the questions given me by Maria, your Chair. There is no COLA for any contractors. Some contractors testified about the hardship of no COLA's before the Board of Supervisors during the budget process. The Board put $1 million on reserve for DPH for merit increases. Spread over 200 contracts, that doesn't go very far. A plan has been given to the Health Commission to focus increases around community-based nonprofits and client-related services as opposed to for-profit hospitals and business-related services.

The increases given out will be a one-time award, and would not be in the contractor's base. There won't be a lot of restrictions on the increase, except that it has to benefit the program and the clients under our contract with them. We would take about the top third of mental health programs as rated by the program reviews, and they would be eligible for awards.

Some of you know that our CFO, Keith Hearle, has taken a job in the private sector. This is a big loss. He's been an extremely valuable member of our staff. There's no news on a new Director of Public Health. The Mayor's Office is taking the lead on that decision.

The Children's Health Initiative which comes from federal legislation is going to provide additional mental health coverage for children. These funds will come to the State but will be administered like private a insurance program instead of through MediCal.

V. MHB COMMITTEE REPORTS

Children's Committee
Ms. Jones: We've set the date for the Mini Summit on Transition Services, and are inviting people from the State Department of Education, the State Department of Mental Health, the Department of Public Health, the Department of Human Services, the San Francisco Unified School District, Juvenile Justice, the Department of Rehabilitation, Kaiser Permanente, and the Foundation for School Linked Services.

The date is January 29, 1998, from 12:30-4 p.m. We still want no more than 30-35 people and we want to keep the focus on San Francisco. I've arranged to fly in a facilitator from Boston. And I have three transition-age kids who have agreed to participate. The focus at the meeting will be on putting up a web page, putting all the transition service information on the Web.

Executive Committee
No report.

Program and Services
Ms. Gilleran: At our last meeting we had a presentation from Roy Crew about the Office of Self Help and from Carol Patterson about the BUILD Project. We also discussed program reviews and I'd like to thank everyone who is making the time to do program reviews. Ms. Leib: I agree. Program reviews go straight to the heart of what the MHB is about.

Public Education
Ms. Leib: The Committee will kick back into business soon. We will consult with the Executive Committee on that.

Consumer/Family Member Task Force
Mr. Leoni: The big item on the agenda was a presentation by Jospehine McCreary on the Provider Network and by Louise Rogers on managed care. We're working on a motion to put more money into outreach on the plan and to get more input from the community on the design of the plan.

VII. PUBLIC COMMENT
Mr. Kalman asked about occupational therapists not being included in the Provider Network, and said that his son, for instance, was not receiving after care. Ms. Burton noted that there are services in the regular part of the mental health system. Ms. Ruffin said she would be glad to talk to Mr. Kalman about his son.

VIII. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:55 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3567

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MEETING OF THE FULL BOARD

Wednesday, November 12, 1997
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS

5 min. **II. CONSENT CALENDAR**
- Approval of minutes from October meeting
- Ratification of Executive Committee action endorsing grant application for Children's Services (See Attachment B.)

15 min **III. ACCESS PROJECT:** Peter Forster, M.D., Medical Director for CMHS, will be present to describe this plan for access to the new mental health system. (See Attachment C.)

60 min **IV. SPECIAL PRESENTATION: PANEL DISCUSSION ON HOUSING**
See enclosed flyer for details.

15 min **V. REPORT OF THE DEPUTY DIRECTOR:**
CMHS Director Jo Ruffin will be present to report.

15 min **VI. MHB COMMITTEE REPORTS**
- Executive Committee
- Children's Committee/Public Relations
- Program & Services Committee
- Consumer/Family Member Task Force
- SFGH CAB
- MHB Representatives to CMHS Committees

10 min **VII. PUBLIC COMMENT PERIOD**
Members of the Public will have 3 minutes each to comment on items within the purview ot the MHB, except for any items upon which they have already commented earlier in the meeting.

VIII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The wheelchair entrance to 1380 Howard is on Grace Street, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Street off Howard.

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SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:30 through the end of the Mental Health Board meeting, to let people into the building.

HOUSING
and Mental Health

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Join us for a panel presentation featuring:

Seth Katzman
Lauren Hall
Lyric Hotel
Conard House

Dovie Hostetler
Kori Koski
Gateway
Salvation Army

Dan Wile
Co-ops and Independent Living Programs
Progress Foundation

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at the regular meeting of the
Mental Health Board of San Francisco
at 6:30 p.m. on Wednesday, November 12, 1997
in the 4th Floor Conference Room
at 1380 Howard Street (at the corner of 10th Street)
San Francisco
Call 255-3474 for more information.

SAN FRANCISCO MENTAL HEALTH BOARD

November 12, 1997

The Minutes of this meeting are missing.

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The Mental Health Board meeting scheduled for December 10, 1997, has been CANCELED

In place of its December meeting, the
Mental Health Board will be having its annual planning retreat.
No resolutions or action items will be voted on at the retreat.

The retreat will be held on December 6, 1997, from 9 a.m. to 4 p.m.
at the Clift Hotel at the corner of Geary and Taylor Streets
in San Francisco.

The next meeting of the Mental Health Board will be
Wednesday, January 14, 1998.
An agenda for that meeting will be sent out
at the beginning of January.

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3751

MEETING OF THE FULL BOARD

Wednesday, January 14, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS

5 min — II. CONSENT CALENDAR
a. Approval of November, 1997 Minutes

60 min — III. RETREAT: Review, discussion, possible action (Attachment A)

20 min — IV. REPORT OF DEPUTY DIRECTOR: Jo Ruffin

15 min — V. MHB COMMITTEE REPORTS
- Executive Committee
- Children's Committee
- Program & Services Committee
- Other Groups
  - Consumer/Family Member Task Force
  - SFGH CAB
  - CMHS Committees

10 min — VI. REPORT OF THE NOMINATING COMMITTEE (Attachment B)

10 min — VII. PUBLIC COMMENT PERIOD

VIII. ADJOURNMENT

PLEASE NOTE: Since there was no meeting of the MHB in December there are no minutes included in this mailing.

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UNADOPTED MINUTES
Wednesday, January 14, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Sylvia Shue, Ed.D.; David P. Smith; Shawn Thomas; Lora Traveler, M.A.; Chester Villalba.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Anita Burton; Lois A. Jones.

BOARD MEMBERS ABSENT: Darwin Dias; Gloria Samayoa.

ADJUNCT BOARD MEMBERS PRESENT: none

OTHERS PRESENT: Jo Ruffin (CMHS); Collins R. Munns (CMHS); Bob Schreiber; Mike Wise (Consumer/Family Member Task Force); Annamarie Hewson (Consumer/Family Member Task Force); Marion Keller; Emeric Kalman (Family Member); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:36 p.m. She asked the two newly-appointed Board members to introduce themselves.

Mr. Smith (appointed by Supervisor Sue Bierman): I've been coming to Mental Health Board meetings on and off for some years. I want to get involved in supporting the mental health system. I'm a consumer.

Mr. Thomas (appointed by Supervisor Leslie Katz): I've been a consumer for 14 years. I'm working as a Peer Counselor at Jail Psychiatric Services for 12 hours a week and have been doing this for a little over a year.

II. CONSENT CALENDAR

RESOLUTION (MHB-98-01): Be it resolved that the minutes of the Mental Health Board meeting of November 12, 1997, be approved as submitted. (Passed)

III. MENTAL HEALTH BOARD RETREAT

Ms. Leib announced that the purpose of this agenda item was to take action on the planning work done at the MHB Retreat on December 6, 1997.

Ms. Leib: I thought that was an excellent day. I thought the Retreat went well.

Mr. Shipley: We haven't read the Mission Statement at the beginning of this meeting which is what was agreed upon at the Retreat. Ms. Leib: First we have to approve all the recommendations from the Retreat to make them official.

Ms. Leib: Let's concentrate on the top three goals for the next year. Are they feasible? Are they things we want to do? Are they things we can do?

Ms. Leib then asked that everyone take a couple minute to review the following goals:

1. To improve communication with CMHS so as to establish follow through and consistency of policies that affect Mental Health Services and consumers in regard to:
   - Development of peer counseling standards (Take it to the state level for development of a state standard)
   - Development of an Education Series for Program Directors
   - Develop ways for the Mental Health Board to evaluate consistency of Mental Health policies.

2. Do a review of the state of Mental Health in San Francisco
   - What is the need?
   - Whom do we serve now?
   - How does the Mental health community get a City policy?
   - How can we help the City develop a policy on Mental Health (ongoing)

3. By February, form a Policy and Education Committee to educate policy makers to develop 2-year strategies that focus on individual issues as follows:
   - Develop an analysis of the expense of timely care vs. emergency
   - Compile a resource sheet of Mental Health Services that informs people about where to get help.
   - Use the Annual Report to educate.
   - This committee will ask Board members to work on projects.

Ms. Planck: With regard to the peer counseling standards in Goal #1, the Program and Services Committee has been working on these. Ms. Leib: Is it the Committee's idea to develop standards to take to the State?

Ms. Gilleran: So far we are just exploring it, seeing what the status quo is and finding out what problems there are. We are poised at the point of finding out what needs to be done. We're finding out what the legal limitations are. We're clarifying tangles, such as

the situation of consumers who are employed to do a job, but are not being treated as trained professionals. There are also issues of confidentiality. We see that the consumer-employee is in a vulnerable position. They can't do the job without being a consumer, but admitting to being a consumer can make them vulnerable.

Ms. Planck: We've heard stories of confusion on the part of supervisors about whether they were supervising or counseling.

Mr. Shipley: The current peer support job announcement through Civil Service says under the job description that the peer counselor may do case management, or run groups or may be required to do charting. A lot of peer counselors getting training from Carol Patterson or Roy Crew do not get training in charting. The State is trying to gather together information about training of peer counselors, because it is different in different counties.

Mr. Thomas: Peer counseling is what I do for a living. I got a letter from Stephen Mayberg, the Director of the State Department of Mental Health, that I will be meeting with him in about 3 weeks on this issue. The training for peer counselors is not standardized from county to county. I will be glad to take your concerns to my meeting with him.

Ms. Ruffin: We do have a staff committee that works on peer counseling standards and grievances. Tina has been working on that Committee. Ms. Leib: It sounds like we should meet with them. Mr. Shipley: I believe Evelyn Balancio is in charge of the Committee in Tina's absence.

Mr. Villalba: I'm not sure what the MHB's role is in developing standards. Do we develop them? Ms. Leib: We certainly advise. And if we're getting concerns from consumers about problems, we can come up with our list and respond to their list.

Ms. Gilleran to Mr. Thomas: You are invited to come to the Program and Services Committee and meet with us on this issue. Mr. Thomas: I'll be glad to come.

Dr. Shue brought up the recent workshop on the American with Disabilities Act and peer counseling. Ms. Gilleran: The consumers felt that the worst violations were being made by supervisors in the mental health system.

Ms. Ruffin: The staff of CMHS who are dealing with these issues would be glad to work with you on them. We're working hard with our staff on training and supervision issues. (To Ms. Gilleran:) I'll ask Evelyn Balancio to call you if you like. Ms. Gilleran: Yes.

Ms. Leib: Our plan then would be to coordinate the development of standards and then approach the State. Ms. Gilleran: We're not ready to approach the State yet. Ms. Leib: It's a two-year goal and it sounds like a two-year project.

Mr. Shipley: We've been looking at this issue at the Community Advisory Board at San Francisco General Hospital, too. We've gotten training materials from San Mateo and Marin Counties. I have a meeting with Aline Womack next week on getting more peer counselors hired and trained. Alameda County is training their peer counselors through the Berkeley Drop In Center. They go through a whole gambit of training on case management, group facilitation, money management, anger management, and charting, Whereas the training here in San Francisco that comes from Carol Patterson has no training on charting among other things. Roy Crew and Kinike Bermudez put their own twist on their training. The last training done was for the DMDA Buddy System. Roy has his own training for his Office of Self Help staff. Even in San Francisco there is not a real solid consistency in training.

Ms. Gilleran: With regard to bullet 3 under Goal #1, this is really a matter of follow through, rather than consistency. We're wanting to know what happens to our recommendations. We want to evaluate the follow through on our MHB recommendations to CMHS.

Ms. Leib: Sometimes we're asking for a report and sometimes we're asking for a comment. It's up to us to remember, not Jo.

Ms. Ruffin: There is also a question raised here about educating program directors.

Ms. Leib: Here's an example—continuing education courses for doctors on mental health issues.

Mr. Villalba: Is this Board to develop an educational series for program directors? I don't think so. Ms. Planck: This is worded incorrectly; it should be for *medical practitioners*. My doctor said to me that the biggest unresolved healthcare crisis in the country is mental health. Maria worked in the liver transplant Department at UCSF. They were very interested in her work in mental health. Ms. Leib: I did this course. I set this up. I started on it a year and a half ago. I'm very happy M.D.'s are going to have a bit more training on these issues. I'm really happy Dr. Forster thought this was something worthwhile and picked up the ball and ran with it. There is so much happening in mental health, it seems M.D.'s and nurses should have required updates on mental health every couple years—and as it turns out, they agree. We sent out 85 surveys to M.D.'s and got back 60, which was a remarkable return rate.

Ms. Ruffin: We're co-sponsoring this training with the Community Health Network. The CMHS Medical Director and UCSF are working together on it. We do training in a whole variety of areas. Would you like me to send you copies of the trainings we're offering? Is the Board interested in promoting certain trainings?

Ms. Planck: We've been talking about changing our Public Relations Committee to a Public Education Committee and there's a whole area where we could support

educational efforts, with the general public, with M.D.'s, and with the Board of Supervisors.

Ms. Gilleran: What we are really saying is to improve communication, and so we're saying we'd like to work more closely with CMHS to promote trainings. Dr. Shue: Peer counselors are needing training on sensitivity for program directors on that issue. A woman at the Law Center workshop said that peer counselors can get burnt out doing case management. Who takes care of their needs?

Ms. Ruffin: There is a great deal of training that goes on inside our system.

Dr. Shue: The second bullet under Goal #1 is about making sure when something new comes down the pike that it really gets implemented.

Ms. Gilleran: Developing peer counseling standards for the State is a goal we could aspire to over a number of years. Dr. Shue: We might create evaluation instruments and then pilot a program after that. Ms. Leib: I think peer counseling is worth keeping around, but if it is having problems that might sink it, then we have to address them.

Mr. Villalba: Perhaps what we should do it ask someone to get the wording right on the Goals and then present the edited version for a vote at our next meeting. These are not ready as they stand. The Executive Committee could rework this and put it in some kind of frame.

Ms. Ruffin: Goal #2 regarding the Annual Report is pretty much assigned to the Executive Committee. Ms. Leib: Yes, we're already working on it. We're hoping to have a draft done by the end of January. Dr. Shue: How about the Program and Services Committee taking responsibility for working on Goal #1? Ms. Gilleran: Yes, Committee members could work on the wording together in our next meeting. Ms. Leib: Okay, Program and Services will put it into digestible form at their meeting and then we'll see it again at the February MHB meeting. It sounds like everyone agrees this is something we need to do.

Dr. Moses: I don't want us to forget on page 5 the issue of cultural competency. We spent a long time discussing it at the Retreat. But a Cultural Competency Committee does not show up on page 5, and I don't want it to disappear. Mr. Villalba: Is it possible to ask a member of the MHB to participate on the CMHS Cultural Competency Committee? Ms. Traveler: I think it's important to have that Cultural Competency Committee. I feel like it's very important. It's another way to assure that our Board is having continual dialogue on subjects that are sensitive.

Ms. Ruffin: Regarding the resource sheet under Goal #3, the Department is developing a consumer handbook which we will be bringing to you.

RESOLUTION (MHB-98-02): Be it resolved that the following members of the Mental Health Board be granted leaves of absence for the meeting of January 14, 1998: April Martin Chartrand and Lois Jones. (Passed)

IV. DEPUTY DIRECTOR'S REPORT

Ms. Ruffin reported as follows: I wanted to thank you for including me in your Retreat, and I want to commend you on the work you did. I want you to know that the staff of CMHS is available to you as you flesh out your work areas.

We are moving toward our April 1st implementation date for Managed Care, and we will meet it.

We have a Community Forum coming up which will focus on the issue of grievances. A the last Forum there was a lively discussion and people made it clear that they wanted more discussion about grievances.

Tina Yee is on leave. She has had surgery and will be needing additional surgery.

We are getting the Access Team hired and are training staff on procedures.

We are very close to naming a new director for the Family Mosaic Project. Sai-Ling Chan-Sew has been covering the Project in the interim. The State is visiting the Project tomorrow to review the program. We want to convince the State Department of Health Services to continue to fund us. Our contract is up next year.

The Family Mosaic Advisory Council has been very active in helping us with staffing and morale issues. We are working on making the Project more culturally competent.

Dr. Moses: Since the director's position has been vacant for almost a year, could that money be used to increase services? Ms. Ruffin: We can look at that. Perhaps they can be used for one-time expenses.

Ms. Ruffin continued as follows: The Cal Works program is starting. There is now a clock on people's benefits. The County has created Cal Works to work with TANF families (Temporary Assitance to Needy Families, which has replaced AFDC) to help them find jobs and get services so they will be ready when time runs out on their benefits. Mental Health Services and Substance Abuse Services are both involved. We're developing a Cal Works proposal to integrate mental health and substance abuse services into the program. An RFP will go out on this. We agreed to hire a coordinator to help re-train DHS staff who will become job counselors in this new world. Reiko True, former Director of Mental Health Services, will be working on this project for us short-term.

We're in the middle of budget development. We're asking for additional funding to provide managed care for the indigent population, and to increase our pharmacy budget, so first-line medications can be available to all who need them.

We're working with the Coalition on Homelessness and Supervisor Sue Bierman on a proposal for mental health treatment on demand. We met with Supervisor Bierman this past week, and will be working on a meeting with Supervisor Bierman and the Mayor's Office.

I want to thank everyone for coming to Supervisor Bierman's Hearing on Mental Health and showing your support. All of the work you put into that hearing is paying off.

VI. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib reported that she and Ms. Gilleran will be working on a revision of the Bylaws of the MHB and should have a draft done by the end of February.

Children's Committee

Ms. Leib reported that the Transition Services Meeting was scheduled for March 20th. She also noted that she has asked Dr. Beauford to be the Chair of the Children's Committee since the current Chair, Lois Jones, is now finishing her second term on the Board.

Mr. Villalba: I attended the Mayor's follow-up to the Summit on Children and Youth. The most impressive part was the Youth Task Force, the young people themselves. They were just wonderful. The day was really worthwhile. The priority setting was a bit of a hodge podge, but there was a lot of commitment. Mental health was integrated into the needs assessment and priority statements.

Program and Services

There was no meeting in December.

Consumer/Family Member Task Force

Mr. Leoni: This is kind of a painful report. The CTF is currently doing some soul searching and it will take a couple months more. The Task Force is a group of people who are not experienced with public debate. On the Task Force, almost everyone speaks on every issue, and the concern people feel leads to strong feelings that can lead to a lack of decorum and that can create problems.

Three or four years ago we worked with Trudy Fulton-Smith to develop a handbook, which was never fully adopted. Problems have been flaring up in the last few months. The MHB Executive Committee wrote a letter to the Task Force requesting us to shut down policy discussions and get our house in order. We're doing that not just because of the letter, but because we have been feeling the problems ourselves. We're committed

to being a voice for all consumers. If contention in our meetings is going to make it uncomfortable for people to attend, then that's a problem.

Mental health consumers have a lifetime of being told what to do, and can take the attitude: Don't you tell me what to say.

This is a hard issue which will take a lot of energy to solve. We've been given an offer of assistance from Rinna Flohr, who said that she would come on her own time and facilitate a meeting for us.

It's only been the last 3 months that things have gotten out of hand. During the past year we've done some very good work, such as on the Implementation Plan and the discussion on the process of the Bed Committee—which resulted in consumers having direct input , and in the hiring of consumers to participate on the Committee. I feel a little uncomfortable with us taking a sabbatical, but hopefully the Community Dialogues will take up some of the slack in the meantime.

Ms. Traveler: How long do you plan to shut down? Mr. Leoni: Another couple months. One other problem we face is that we have no committee structure, so there is a lot of pressure when we are faced with deadlines, and when people are not skilled in process. Ms. Gilleran: We respect what you're doing. We wish you success.

Community Advisory Board, San Francisco General Hospital
Mr. Shipley: We had a presentation by Phyllis Harding on the Mental Health Rehabilitation Facility and the complex problems they are dealing with. They have discovered that of 133 people, a lot of them are acute, not just in terms of mental health, but in terms of physical health. The top floor has been set aside for medical problems, and they are having to extend that and use part of the second floor, too. For many of the consumers this is the first time they have gotten dental care, and many of them are extremely grateful. The MHRF is having to reorganize personnel to meet the medical needs of the clients.

Ms. Planck: Saumitra SenGupta did a survey that showed that the MHRF clients have more severe medical needs and more severe psychiatric needs than expected.

Ms. Ruffin: Historically the medical issues have been under-identified. We're doing much better now. There has been a problem with out-of-county facilities where medical care has not be as available. The advantage of the MHRF being located at San Francisco General is that there is medical support from the hospital. We just met with the MRHF and agreed with the changes in their staffing so they can respond to the medical issues and the severity of the psychiatric issues.

Ms. Traveler: My sister had a very harrowing experience last week. She takes 10 medications, including 4 for physical needs. Her medication for mental health built up

until there were three days when she couldn't sleep. What I did was to call the Mobile Crisis Unit. They were wonderful.

They let me know when they would be there, and came on time an hour after I called. They talked with my sister and went through all her medications. What they did was exactly what was needed at the time.

When my sister's doctor retired, a new doctor took over. But they have tremendous case loads, and cannot call you back. Her therapist was away, so Mobile Crisis was who I called. They were just great, so much of a help. Everything they said they'd do they did during a very severe crisis.

Nominating Committee
Dr. Moses announced the following slate of officers for the election to take place in February:

For Chair—Maria Leib
For Vice Chair—Peggy Gilleran
For Secretary—Toye Moses

VII. PUBLIC COMMENT
Ms. Hewson: I am very concerned about the MHRF. They are still smoking there, despite an ordinance from the State about a smoke-free environment. I sent a letter to Mr. Cordova, Executive Director of SFGH. Mr. Cordova sent documents about a smoke-free environment to Mary Louise Fleming, but she's kind of resistant to doing anything about stopping smoking. Ms. Leib: Nobody smokes in the building.

Ms. Hewson continued: My son smokes a whole lot. He was not a smoker before going into the hospital. It's very important for Mary Louise Fleming to respond to this issue. I wonder if the Mental Health Board can intervene.

Ms. Leib: The Board has taken a position on this issue that during a crisis is not the time to go cold turkey on smoking. We do not advocate that clients smoke in the facility, but that they go out to the courtyard. We've had a number of lengthy discussions (and most of our members are not smokers) but we think it would be a cruel punishment to take smoking away in a crisis.

Ms. Traveler: I'd suggest that the Board write a letter to Mary Louise Fleming asking for a committee to look into this.

Ms. Planck: We've sent out a survey on smoking at inpatient facitilies to our Consumer Advisory Team which has 80 members. We got our 45th response today. We could take those responses and the MHB position to the hospitals and to SFGH to get a dialogue going. We sent a letter before to the hospitals and got no response.

Ms. Hewson: The MHRF operates under the same license as SFGH and they have stopped smoking at the General Hospital.

Mr. Leoni: I think it's important to offer nicotine patches to clients so they can stop smoking, but I think it's cruel to stop smokers from smoking in the midst of a crisis. I think that Annamarie's concern about her son is important, too, and perhaps there would be some way of discouraging people from starting smoking.

Ms. Keller: I have a son at the MHRF who used to be a heavy smoker. At St. Francis Hospital he was not allowed to smoke, and that did absolutely no harm to him. Now at the MHRF, he is allowed to smoke out on the terrace, and his room just stinks of smoke. I can't buy it that it's inhuman and cruel punishment to stop someone from smoking. Everyone else in the city is on the side of stopping smoking. My son is stabilized now and not in crisis.

Mr. Leoni: I am concerned about managed care and think there should be more materials about managed care coming through the Board. Big changes are going on. A switch is being made from having coordinators to care managers. Fee for service is over. There's been no place for discussion of these changes at the committee level of the MHB, and the system is about to go live with these changes.

Mr. Villalba: I think that is an important comment. Managed care as such is controversial and it's got bugs and no system is perfect, but it's important that we follow managed care and get reports.

Mr. Kalman: I'm sorry I couldn't have input at the December 4th hearing. But I had the occasion to see a video of that hearing and I recommend that you review it. I don't know if you know Supervisor Yee is planning to introduce a ballot initiative on the people's right to know, regarding the site approval ordinance. Ms. Leib: Yes, we're aware of that and are following it closely.

VIII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:45 p.m.

Addendum to Minutes: Two new members were appointed to the MHB in January 1998: David Smith and Shawn Thomas. Supervisor Sue Bierman expressed her pleasure at appointing Mr. Smith, and Supervisor Leslie Katz said that she wanted to acknowledge Mr. Thomas for his work with Jail Psychiatric Services and with the Center for Special Problems.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD

Wednesday, February 11, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS

II. CONSENT CALENDAR (5 minutes) *See Attachment A*
- a. Approval of November, 1997 Minutes
- b. Approval of Requested Leaves of Absence
- c. Ratification of Action Taken by Executive Committee

III. ELECTION OF MHB OFFICERS: (20 minutes) *See Attachment B*

IV. ISSUES FROM RETREAT (40 minutes)
- a. Goals: Discussion, approval of Goal # 1, as identified at Retreat *(Att. C)*
- b. MHB Committee Structure: Discussion, approval of revised structure *(Att D)*

V. REPORT OF DEPUTY DIRECTOR: Jo Ruffin (20 minutes)

VI. MAY (MENTAL HEALTH MONTH) RECEPTION : (10 minutes) Shall MHB host event as described in *Attachment E?)*

VII. MHB COMMITTEE REPORTS (15 minutes)
- Executive Committee
- Children's Committee
- Program & Services Committee
- Other Groups
  - Consumer/Family Member Task Force
  - SFGH CAB
  - CMHS Committees

VIII. PUBLIC COMMENT PERIOD (10 minutes)

IX. ADJOURNMENT

SUNSHINE ORDINANCE

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DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES

Wednesday, February 11, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Sylvia Shue, Ed.D.; David P. Smith; Lora Traveler, M.A.; Chester Villalba.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Mickey Shipley; Shawn Thomas.

BOARD MEMBERS ABSENT: none

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni

OTHERS PRESENT: Collins R. Munns (CMHS); Mike Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Mark Adamek (Spiritmenders, Community Advisory Board, SFGH); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:36 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-98-03): Be it resolved that the minutes of the Mental Health Board meeting of January 14, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-04): Be it resolved that the Mental Health Board grants leaves of absence for the February 11, 1998, meeting to: Mickey Shipley and Shawn Thomas. (Passed)

RESOLUTION (MHB-98-05): Be it resolved that the Mental Health Board ratifies the action of the Executive Committee in sending a congratulatory note to Dr. Mitchell Katz upon his appointment as Director of the Department of Public Health. (Passed)

III. ELECTION OF MHB OFFICERS

The following were unanimously elected as officers of the Mental Health Board for a two-year term:

Chair—Maria Leib
Vice Chair—Peggy Gilleran
Secretary—Toye Moses

IV. ISSUES FROM THE RETREAT

Goal #1

Ms. Leib called attention to Attachment C which listed Goal #1 from the MHB Retreat, then said: The Program and Services Committee worked on this issue. This will be the work we'll be doing for the next couple years and beyond, so this is really important.

Ms. Planck: Quite a few people worked on this. I want to especially commend David Smith for coming to the meeting prepared with recommendations and for jumping right in at his first MHB committee meeting.

Dr. Beauford: This is a much cleaner version of the goal. Ms. Gilleran: This is our primary goal. Ms. Planck: The Committee felt that many of the things the Board does fall under this goal. So this is not a dramatic change in direction. It's more a clarification. Ms. Leib: The new managed care system goes on-line April 1st, so it's very important for us to be clear about our goals.

RESOLUTION (MHB-98-06): Be it resolved that the Mental Health Board adopts the following wording for Goal #1 for 1998 and beyond:

To enhance communication with CMHS, so as to establish consistency in follow through of policies that affect mental health services and consumers, in regards to, but not limited to the following:

Development of standards for peer counseling performance, training, and supervision.

Encourage the development of education series for general medical providers, alternative medical providers, and the public regarding mental health issues.

Develop ways for the Mental Health Board to evaluate the consistency of mental health policies, and follow through on Board recommendations regarding these policies. (Passed)

MHB Committee Structure
Ms. Leib: The Executive Committee and Program and Services both worked on the ideas in Attachment D for committee structure. The proposal has 3 standing committees; we could have four. Quarterly and seasonal committees are also possible. For example, the budget is a priority from now through June or later. It seemed like making it a quarterly meeting might ease the burden on Board members.

Ms. Planck: Also, there were so many committees we thought of that we decided to try to group the ideas into committees that made sense.

Ms. Leib: Public Relations, for example, could just meet to plan an event for several months in a row, and then not meet for several months. That would free us up to do other public relations work, such as going to other people's events and meetings. I go to a lot of meetings of Democratic Clubs to talk to people about mental health issues. With regard to cultural competency, I heard you saying how important it is.

Ms. Planck: This is the time for input because the Executive Committee and the Chair make the committee decisions, but they really want to do what the Board wants.

Dr. Beauford: I think this flexibility of structure allows me to participate in more of the committees. Ms. Traveler: I'm glad to see the cultural competency breakdown of issues and needs. Ms. Gilleran: Regarding the Legal Committee, It could be quarterly or PRN, as it essentially was in the case of the Assembly Bill that came up recently which we had to act on immediately. Or if a patient's rights issue came up, we could call a meeting right away instead of waiting for a regular meeting to come around which could make a long delay.

Ms. Leib: I think this flexibility allows for better use of the talent of the Board. Ms. Gilleran: I like the ideas for the Public Interface Committee. This gives us a chance to do some things we haven't done before, such as the proposed event for May which I think is a very good idea.

Ms. Leib: We really want your input on this, because sometimes we've had trouble filling committees. We'll take these forms which you are filling out tonight on your own personal choices for committee membership back to the Executive Committee which will put together a new committee structure.

V. DEPUTY DIRECTOR'S REPORT
Collins Munns reported for Jo Ruffin as follows: Jo's at the California Mental Health Directors meeting in Long Beach.

First I'd like to ask for half an hour at your March meeting, with your concurrence for a presentation of a readiness report prior to consolidation of outpatient services on April

1st. Unlike in the past, that date will not change. We will go forward with consolidation on April 1st.

There has been an official disaster declared in the County of San Francisco as of last Wednesday at 5:30 p.m. Under that declaration the County employees have a legally-mandated responsibility to make themselves available for coverage mainly at City shelters. Mental health employees have served 12-and-a-half hour shifts, mostly on a volunteer basis. Linda Wang is our Disaster Coordinator. We're not sure how long this situation will last. As you know more storms are lined up off the coast. We provide crisis intervention and respond to depression in reaction to the crisis. I heard a man on the radio saying that it was an irritation to have to move out of his home, but most people react with anger, a sense of loss, and depression.

Ms. Leib: I read that suicide rates stay up for a long time after a disaster. Mr. Munns: When people return to their homes and see the mud and the loss of personal belongings, that can be very depressing. Mr. Villalba: What is the relationship of the disaster service to the services for the homeless. Mr. Munns: In terms of mental health, there is an ongoing program of outreach to the homeless mentally ill, which functions on a 7-day-a-week basis. During a crisis, there is an increase in the workload. The regular shelters can't handle the increase so they set up additional shelters, and that's where the City employees assist with staffing.

Mr. Munns: With regard to the budget, as you may or may not know, because the economy has been booming and revenues being generated by taxes and fees have been increasing, there will be an overall increase in the Public Health Budget for fiscal year 98/99 of $86 million over the current budget, which is $837. This is a process we're involved in. The budget will be submitted to the Health Commission for review on February 17th. Then it will be submitted to the Mayor's Office. Then it will be submitted to the Board of Supervisors during June. This is a process, but it does look very good compared to budgets in past years.

One of the DPH initiatives which is brand new is to set up Departmental reserves of $5 million from the surpluses, so in the future when there is a shortfall, there will be something to fall back on. For a budget this size, $5 million is a very conservative figure.

The mental health budget will have a baseline increase from $137 million to $140 million, or a $2.77 million increase. Most of this increase will be targeted to salary increases, which are tied into the Memorandum of Agreement with City employees. Some of this increase will cover MIS equipment and maintenance need for the implementation of managed care.

There is also a supplemental budget action in the process of being submitted to convert 38 FTE's currently working under contractors to City employees. The positions which will be moved into Civil Services are primarily positions which are under managed care, for example Child Crisis and Mobile Crisis. We need to get the managed care staff

out from under contractors, so they can make more objective decisions about authorizing care.

This also includes some funding to support a policy on a single standard of care. Right now there is no funding for the indigent population. We either have to have that money or we have to have two systems of care, one for people with Medi-Cal and one for indigent people. The Health Commission has approved the initiative of Community Mental Health Services—which is supported by the Mental Health Board—for a single system of care. The funding requested is $3 million. Also there is a request for $2.7 million for additional pharmaceuticals, to expand the number of newer medications which can be used. This makes a total of $5.7 million requested.

Also there is a request for $2.8 million, which is a lower priority, broken out in this way:

a. $270,00 would cover the cost of mental health consultation for substance abuse providers and primary care providers.

b. In addition, we are assuming that when the system expands, another 4,000 clients will be added at 12 visits per person per year. Many advocates have said the number of clients is far too low and the number of visits is too low. So $1.2 million is being requested to increase the number of visits to 24 per year for a total of 4,600 new clients.

c. Further, $31,000 is being requested for outreach services to the homeless mentally ill, to expand current services.

d. Another $811,00 is requested to set up a new 10-bed short-term crisis residential center as an alternative to hospitalization. There are currently about 30 such beds in the City. By comparison, San Diego has about 120 of these.

e. $42,000 is being requested for Patients Rights Advocacy Services so staff can meet the increased workload to be brought about by managed care.

f. $335,000 will be for a 12-bed long-term (6-18 months) residential treatment facility for people who are dually diagnosed.

g. There would also be a joint project on vocational services with the Department of Rehabilitation. $83,000 would be used for clients speaking Mandarin and Tagalog.

This will be on the Health Commission agenda for February 17th, so there's still an opportunity to speak to any issues on this or any other part of the budget.

Ms. Traveler asked about the difference between the increase from $137 to $140 million and the supplemental increases. Mr. Munns replied as follows: The $140 million is the baseline budget. In addition to that there are requests being made for $3 million for the

single system of care, $2.7 million for pharmaceuticals, $2.8 million for additional programs, for a total of $8.5 million. Add that to the baseline of $140, and if everything is approved, the total budget for CMHS would be $148.5 million for fiscal year 98/99.

Ms. Traveler then asked about the transfer of positions from contract agencies to Civil Service. Mr. Munns: The 44 positions we are proposing to move from contractors to Civil Service is part of a larger number of positions we hope to be able to move over time. In total we hope to move about 130-140 FTE's.

Ms. Traveler ask about the 10-bed short-term unit, specifically why it was to be short-term. Mr. Munns: That facility is intended as a short-term crisis unit. The intent is for it to serve as an alternative to hospitalization. The intent is to push down acute inpatient costs, so that the system will be paying $200 a day instead of $800 a day in the hospital. This unit is not intended to be a substitute for housing.

However, one thing I'm working toward is to get away from these smaller 10-bed facilities to larger facilities, such as 12-16 beds, to get economies of scale. In San Diego most of these kinds of facilities are at 16 beds, and we had very good success with them. If you have more than 16 beds, you are into a different licensing category.

Ms. Traveler asked why the proposed vocational program was to be provided only to Mandarin and Tagalog speaking people. Mr. Munns: I expect it was because those populations are the most underserved locally and statewide. The Department of Rehabilitation came to us because they were being urged by the federal government to set up these programs.

Ms. Traveler: Thank you. This has been a very clear report.

Dr. Moses: Could you give us an example of the transition of FTE's from contractors to Civil Service? Mr. Munns: Westside Crisis is mixed staff. Contract staff and Civil Service staff are getting different salaries for doing the same work. The same is true for the Family Mosaic Project.

Dr. Moses then asked about Forensic Services. Mr. Munns: The person to ask about Forensics is Jo Robinson. We're working with them on client transition from the Forensics system out into the community and into the CMHS system. We've added a case manager to Forensic Services to help with transition.

Mr. Leoni: The new money we are talking about is actually money that is coming back to mental health. In earlier years, we were shutting down beds at Napa State Hospital at $100,000 each for a total of about $10 million. This savings went to other City departments despite attempts to keep it in mental health. Sue Bierman will be holding additional hearings and there will be a chance to argue for more increases.

Dr. Shue asked about the contract with the Department of Rehabilitation, and if CHMS is going into that contract for leverage. Mr. Munns: The percentage of the budget in San Francisco devoted to vocational services is lower than in many larger cities. For example, San Diego has a budget of $100 million, but vocational services two and a half times as large as San Francisco. Not enough attention has been paid to vocational services. This program will be done in conjunction with RAMS. CVE was going to do it originally, but when they heard RAMS was interested CVE decided RAMS could do a better job with that population. CVE will now be giving RAMS technical assistance.

Dr. Moses asked about the status of the Family Mosaic Project. Mr. Munns: We've hired a new director, Dr. Gary Zomalt from San Diego. He started on January 15th. We are now seeking a new clinical director. On January 15th, Dr. Zomalt's first day on the job, the State Department of Mental Health and Health Services came to do a program review. The staff made a very successful presentation. The State Department of Mental Health is recommending an additional 3 years of funding for the program. The research presented shows some astonishing results that FMP is achieving.

VI. MAY (MENTAL HEALTH MONTH) RECEPTION

Ms. Leib: This event proposal comes straight out of many of the things we talked about at the Retreat. We've thought for some time that we need to develop a better relationship with the Board of Supervisors. Jo made the suggestion and Collins agreed that we should invite the Mayor, too, because he's been supportive of mental health services.

Ms. Gilleran: There is just one law at that level: the powerful and the punchy get noticed. Ms. Leib: I think we need to be more punchy. Ms. Planck: Our recognition is better now than in prior years. This is a good time to put faces to the names. Ms. Leib: usually they only see us when we are asking for something. This time we will be thanking them.

Ms. Traveler: I would like to request that Sue Bierman send one of her aides to the MHB meetings since there are now 3 aides per supervisor. Ms. Planck: I'll call and make that request.

Ms. Gilleran: I feel like our population does not have stature in the minds of our City leaders. When a population has more power it has more stature.

Ms. Traveler: This kind of setting would be a chance to talk one on one with the Supervisors. A chance for them to ask us questions. We can let them know that they have someone who they can run questions by. In this kind of setting, we have the responsibility to dialogue and get them to focus in. We're here to provide information. We're advocates.

Ms. Planck: Yes, we can present ourselves as able to help. Perhaps our constituency isn't powerful, but we can help when the Supervisors are under pressure.

Mr. Villalba: I'm wondering what the purpose of the event is? Is it to educate the Supervisors about the Board and mental health services? Could we have a handout sheet or a display showing what the extra services are that San Francisco is providing.

Ms. Leib: The Annual Report will be very useful in talking about services. The timing, holding this event in May, will be very good vis-a-vis the budget process. We want to reinforce what they will be getting from the Mayor's Office in terms of budget.

Mr. Villalba: So the Annual Report is our public relations? Ms. Leib: Yes. Ms. Planck: The Annual Report is specifically addressed to the Board of Supervisors on the state of mental health services. It is a mandated duty of the MHB.

Ms. Chartrand: I think the Board could do some more discussion of this issue. I always send my Supervisor announcements about my appearances and go to events where she's speaking. I also send her notes. Her aide knows me now. Sometimes I just pop in the office to say hi, then move on. Ms. Planck: You really have a talent in that area and perhaps you could do a training for us on how to do it. Ms. Chartrand: It would be good to do something ongoing about this.

Mr. Leoni: This event would have to be noticed as a public meeting and that may affect the format of the event. April, your idea is right on. I've done lots of advocacy and I go to meetings where the Supervisors are and cultivate the aides, because they are the front door to the Supervisor.

RESOLUTION (MHB-98-07): Be it resolved that the Mental Health Board sponsor a reception in May 1998 (Mental Health Month) for members of the Board of Supervisors and their aides. (Passed.)

VII. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib reported that the CMHS Committee on a Culturally Competent System of Care meets on the 4th Monday of the month from 9-11, and asked if a Board member would like to serve as liaison. Ms. Chartrand said that she would attend.

Ms. Leib also asked for someone to speak at Spiritmenders in response to a request from that organization.

Ms. Leib then discussed the site notification ballot initiative as follows: Supervisor Yee is sponsoring an initiative on site notification. I've requested a meeting with him and other supporters of the initiative, to include Mary Sue and me and another Board member. He has agreed to the meeting. Dr. Moses volunteered to attend with Ms. Leib and Ms. Planck.

Ms. Leib: Mary Sue and I have met with the Executive Committee of the Consumer/Family Member Task Force. They are having a meeting on February 21st facilitated by Rinna Flohr, and they hope to be back in business mode by May.

We currently have some Board openings. Our best recruiting comes from Board members. We need two family members and one mental health professional.

Children's Committee
Ms. Leib: I'm happy to announce that Jim Beauford has agreed to at least be interim Chair of the Children's Committee.

Dr. Beauford reported as follows: We've moved the Transition Services Meeting to April 24th. We wanted to do that to have a tight ship. We wanted more time to develop the program and to make sure we get the key people we want to attend. The key feature of the meeting is the Transition Services Website. This will help with access to services, with the continuity of care, and with networking. It will include the eligibility criteria so people will know how to get into services. We're looking into how to fund it, but it will happen. I'm happy to accept the Chairmanship and look forward to it.

Program and Services
Ms. Gilleran: Our January meeting was almost entirely spent hammering out Goal #1 from the Retreat. We find we work very well together. For the February meeting we are inviting the staff person from CMHS who works with the Peer Advisory Committee. We are formulating lots of questions to ask her. You are all invited to call in your questions to the office.

Ms. Planck: David Smith has agreed to serve as MHB liaison to the Peer Advisory Committee.

Consumer/Family Member Task Force
No report

Community Advisory Board, San Francisco General Hospital
Written report submitted by Mickey Shipley.

CMHS Quality Policy Council
Mr. Leoni: The QPC now has a quality management plan in place which will be starting next month. This has been in the planning stages for a long time.

There was a very successful Community Dialogue on January 31st. Attendance was not really great but enthusiasm was. The focus was on the grievance procedure and problem resolution. There was discussion of recommendations to:

1. Shorten the time line
2. Have an independent ombudsman

3. Have an independent arbitrator
4. Have a consumer on the review panel
5. Have sanctions for provider noncompliance

CMHS Leadership Work Group
Ms. Leib: There was a discussion of the training procedures for ACCESS staff. I think we should follow through on Dr. Forster's invitation to participate in role playing phone calls.

VIII. PUBLIC COMMENT
Mr. Kalman: My son is in the system, so I have 5-6 years of experience of what's going on as a family member. Fortunately my son is still in the family. I didn't throw him into the street to be taken care of by some nonprofit. Supervisor Ammiano is introducing a new sunshine ordinance. I heard on the radio, some managers of nonprofits such as Progress and Tides, speaking against the ordinance. I think there are serious problems. Can we find out what's in the nonprofit contracts? Ms. Planck: Yes. You can go to the contracts office and ask to see the contract for any particular agency. They will let you sit there and read through the entire contract, including the budget.

Mr. Kalman: I would like to see something reported about how many reviews the Mental Health Board does. Ms. Planck: Eight to ten every year.

Mr. Villalba: I notice at some meetings that we have lots of public comment. There are some people who have lots of questions. On the other hand, the Board has huge agendas I wonder if on a rotating basis a Board member could be available to answer questions after the Board meeting. Ms. Leib: People are also welcome to attend committee meetings. Ms. Planck: We can also refer people to the appropriate CMHS staff person. That was a very thoughtful suggestion, Chet. Ms. Leib: Yes. Time is always a tough issue, we could easily go on another hour.

IX. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:59 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD
Wednesday, March 11, 1998
1380 Howard, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. CALL TO ORDER/APPROVAL OF MINUTES, INTRODUCTIONS (5 min.)

II. CONSENT CALENDAR (5 min.)
- Approval of Minutes from February Meeting
- Approval of Leaves of Absence

III. READINESS FOR START-UP: CMHS Report on Status of Preparation for April 1 Implementation of Managed Care: Questions (60 min.)

IV. COMMITTEE REPORTS (20 min.)

MHB Committees
- Executive Committee
- Children's Committee
- Program & Services
- Ad Hoc on Bylaws

MHB Representatives to other Committees, Boards
- CMHS/DPH Committees
- SFGH CAB
- C/FMTF

V. REPORT OF THE DEPUTY DIRECTOR: To include report on Evaluation of Family Mosaic Project (20 min.)

VI. PUBLIC COMMENT PERIOD:
Members of the Public will have 3 minutes each to comment on items within the purview of the MHB, except for items upon which they have already commented once in the meeting. The MHB also accepts written testimony at any time. (10 min.)

VII. ADJOURNMENT

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs, and there is an additional accessible entrance on Grace Alley, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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UNADOPTED MINUTES

Wednesday, March 11, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.; Shawn Thomas.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Darwin Dias; Lora Traveler, M.A.

BOARD MEMBERS ABSENT: David P. Smith; Chester Villalba.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

PRESENTERS
Managed Care: Nancy Presson, Louise Rogers, Steven Seidman, Bill McConnell
Family Mosaic Project: Sai-Ling Chan-Sew, Gary Zomalt, Karyn Dresser

OTHERS PRESENT: Jo Ruffin (CMHS); Sheila Miller (Spiritmenders); Emeric Kalman (Family Member); Marion Keller, L.C.S.W.; Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:37 p.m.

II. CONSENT CALENDAR

RESOLUTION (MHB-98-08): Be it resolved that the minutes of the Mental Health Board meeting of February 11, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-09): Be it resolved that the Mental Health Board grants leaves of absence for the March 11, 1998, meeting to: Darwin Dias and Lora Traveler. (Passed)

Agenda Item V taken out of order:

V. DEPUTY DIRECTOR'S REPORT

Ms. Ruffin reported as follows: Thank you for moving this item up on the agenda. It's my privilege to serve as Chair of the Bay Area region of the State Mental Health

Director's Association (SMHDA). I'll be attending the SMHDA meeting in southern California tomorrow, and will have to catch a plane this evening.

Maria represented the MHB at in working with the Mental Health and Substance Abuse Working Group of the Coalition on Homelessness. Supervisor Sue Bierman, in conjunction with that group, held a hearing on mental health needs. Out of that hearing the Department of Public Health prepared new requests for: additional services for people who are indigent, additional pharmaceuticals for indigent people, and additional initiatives which were incorporated into the budget request.

We were able to get a meeting with Mayor Brown, which included Dr. Katz, Supervisor Bierman, Jennifer Friedenbach from the Coalition, and Jane Kahan from the MHA. We received a very good response from the Mayor. He said he was in support of the requests, although they will depend to some extent on the revenues coming in. He was very pleased to see that the Department had worked with the Coalition in planning this.

III. READINESS FOR START-UP: CMHS Report on Status of Preparation for April 1 Implementation of Managed Care; Questions

Ms. Presson: The managed care plan started 3 years ago when CMHS took over authorization of all inpatient services for Medi-Cal clients. On April 1st we will be taking over authorization for all outpatient services. Our bottom line is to be able to provide services and care rather than having the bottom line of making money.

Ms. Presson then reviewed the organizational chart of the San Francisco Mental Health Plan attached to these minutes.

Dr. Seidman, Access Program Director, then reported as follows: Access is the main entry point. But people can go into any clinic and if that clinic doesn't have a cCura[3] computer, they can call us on the phone. We want to reduce psychiatric emergency services. If we are doing our job right, people will need less in the way of crisis help.

The goals for Access include:

- Reduce PES use
- Provide consumer-guided, culturally-competent, and respectful services.
- Improve continuity of care. (The cCura[3] computer program will help with this.)
- Provide improved linkage between CMHS, CSAS, and primary care providers. We have a don't-drop-the-ball policy. We won't just give someone a number to call. We'll set up a conference call or follow through so we're sure linkage takes place.)
- Develop realistic guidelines for service authorization.

Dr. Moses: I didn't see Forensic Services on the list, do you link with them? Mr. Seidman: Yes, we link with whatever services are necessary. Dr. Beauford: Who will have access to cCura[3]? I'm concerned about confidentiality. Ms. Rogers: Only members of the Access Team will have access to that data. It won't be shared out to all providers, just to people who do authorizations.

Dr. Seidman then made the following points about staff and training:

- The first provider training was held on January 14th.
- Clinic-based team members have been identified.
- Eleven members of the central team are on board
  - Training has begun on the specialized phone and computer system. provider telephone referral service has been operating 9 a.m.- 5 p.m. five days a week since January 1st. The State sent out 100,000 letters, and we have been getting 200 calls a day. No caller went into a hold pattern.
  - Protocol surrounding phone-based authorization of services has been developed.

Ms. Ruffin: Some MHB members offered to help with testing and evaluation. Perhaps we can involve them in some blind calls and evaluations of Access.

Dr. Seidman then discussed the diversity of the Access Team as follows:
There are currently eleven members of the team, 6 female, 5 male, 3 Asian, 4 Caucasian, 1 African American, 1 latina, 1 latino, and 4 gay or lesbian identified staff. The languages spoken by those staff include: Mandarin, Cantonese, Spanish, French, German, and Italian. In the building are staff who speak Tagalog. We also have a contract with Suicide Prevention for additional language capability. We have Russian speakers in some of our clinics. We have AT&T language services as a back up, but we hope not to use that. If we did have to use AT&T, the third person doing the translating would not be a clinician.

Dr. Seidman then discussed the Access process as follows:

- Call to toll-free number or walk in leads to triage and referrals. Access team can authorize services or refer client to appropriate place.
- Telephone authorization will be based on clinical determination.
- Walk in to the System of Care will lead to assessment and referrals.

With some people who call in, we won't be able to assess their needs over the phone, so we will authorize an assessment. Calls will mostly be limited to 15 minutes. We'll be tied in with Suicide Prevention if someone is suicidal.

- A common database will contain information on providers specialties and capabilities.
- Standards of authorization will be developed for all members of the Access Team.

Dr. Beauford asked about the time frame. Dr. Seidman: We're working on a no-waiting-list policy. If we can't determine the client's need on the phone, we'll have the schedules of providers, and can schedule an assessment immediately. Providers have it written into their contracts that they have to respond within 24 hours and they have to see the client within 5 days.

Ms. Leib: What happens when all the lines are busy? Dr. Seidman: The phone system is sophisticated. The first message will say, Thanks for calling, if this is a medical emergency call..., If this is a psych emergency press # (this will page Access and the call will be picked up immediately.) A crisis call can roll over to mobile crisis or child crisis. Mobile crisis has one of our phones in their unit and their office is next door to ours so we can walk over there.

Mr. Shipley: What if a provider has a specialty but is booked, but that provider is the only one with that specialty. Dr. Seidman: When we are doing authorizations, we will have the use of the computer which can chose a provider by gender, language, and ethnicity. We hope to have enough providers that we won't reach capacity on specialties.

Ms. Rogers: One of the key problems is to get a base of providers who will be able to meet the needs of the current clients plus all the new clients. We have worked hard to recruit all current providers into the new plan, even though we are offering relatively low fees. We are currently negotiating with 6 groups:

- Survivors International—a group that works with survivors of torture
- Family Services Agency—San Francisco Psychiatric Affiliates
- Langley Porter Outpatient
- California Pacific Outpatient
- California Detox Program (which is developing a mental health component.)
- Psychological Treatment Associates

We've sent out Requests for Applications so current providers could expand. Twelve applications came in including a couple that have not provided services for the County before.

We are recruiting traditional providers—psychiatrists and psychologists—as well as LCSW's, MFCC's, and masters prepared nurses.

We have 90 more individual applications. We have to credential them and contract with them.

Dr. Moses: Is acupuncture included? Ms. Rogers: This list does not include acupuncture, only what is allowed as billable by the State.

Dr. Beauford: What is the balance between psychiatrists and psychologists? Will psychiatrists be limited to medication management? Ms. Rogers: It will be similar to the past. We have about 150 psychiatrists and 100 psychologists in San Francisco who have been billing Medi-Cal. Psychiatrists won't be limited to just medication management.

In terms of the providers who have applied, they are mostly male and there is a problem with ethnic balance. Eighty-four percent are Caucasian. Part of the mental health network includes foster care providers, which has a high percentage of African

American providers. But in general this is an area of weakness. It's the focus of provider services to improve this picture.

There will be a 6-month grace period for fee-for-service practitioners under the old arrangement to decide to work with us under the new plan.

Ms. Presson: So the big question is: Are we ready? What we've heard from other counties is that you're never ready. But we're ready. I was at an Access meeting, and it's ready. Some of the technical bells and whistles will not be ready, but the team is in place and calls will be answered.

Our eligibility policy became real on December 9th when the Health Commission passed the resolution. If it becomes possible to serve indigent people, through a budget request, will that money be enough—that is still a question.

As we develop hard data about how many calls and what the needs are, we may come back to you for future development of the plan.

Our first contracts have been sent in to the Purchaser's Office, so we can pay providers. Getting the contracts processed is probably the most complex part of the work.

We are still worried about recruiting enough providers, but we have strategies in place to do good recruitment. With regard to our information systems, that is a constant challenge, but we have a plan and we have some very good people working on the interface. We are prepared for the fact that not everything will be perfect on April 1.

The grievance process has been simplified to make it easier to understand. It has been approved for a 60-day period. We are still working on the appeals section. We are looking at the possibility of a third party arbitrator.

We will have an ongoing need for quality management. We have adopted a very ambitious quality management plan. A test of our Mental Health Plan is how well that quality Management plan works.

Dr. McConnell: We do have a thorough or ambitions quality management plan. Everything is processed through the Quality Improvement committees. Issues start at the lowest level and work their way up to the higher levels.

But things also flow in the opposite direction. The Quality Policy Committee (QPC) can assign issues down through the system.

The Mental Health Board has an advisory role with Jo plus membership on the QPC.

(See chart of Quality Management System attached to these minutes.)

We worked on the quality management plan for over a year. In January we started 'exercising' it. The first issues that came out of that process will go to the QPC this month.

Dr. Moses: How effective is the QPC? What is the balance between CMHS staff and non-staff members. Dr. McConnell: The balance is better but we hope to improve attendance.

Ms. Ruffin: Yes, I agree that was a problem. We're going to clarify the agenda and ways for people to participate and we'll be working on how to keep it an active committee. Thanks for your time and attention to the presentation. Thanks to the staff, especially Nancy and Louise—they have designed the whole thing and have trained the rest of us to understand what they were doing.

V. REPORT OF THE DEPUTY DIRECTOR (continued) — FAMILY MOSAIC PROJECT

Ms. Leib: The Family Mosaic Project is one of the key pieces in the entire mental health system. It has blazed trails for the adult system.

Ms. Chan-Sew: We have very good news. We have hired a new Program Director, Gary Zomalt, from San Diego. He has an extremely impressive background. Karyn Dresser is the Evaluator for Children's Services, and has worked for the past 5-6 years collecting data on the Family Mosaic Project (FMP) and Children's Services.

The current FMP contract will run out at the end of this year. We just got news from the State that the contract will be renewed. We're so pleased and so proud of that.

Dr. Zomalt: I'm glad to be here. It's been a joy working with FMP. I started out working with a community program in Watts in 1968 which provided services for families. FMP is a representation of that same approach.

Dr. Zomalt continued his presentation with overhead slides as follows:

Historical Perspectives

In 1989 an interagency process established that 948 children in San Francisco, 10% of the child population, were seriously emotionally disturbed (SED) and at risk for out-of-home placement.

- Almost three quarters (75%) of these children had history of prior mental health treatment.
- Over half (54%) had history of psychiatric hospitalization or incarceration.
- Over half were having trouble in school and receiving special education services.
- These children being served by five different public systems—Social Services, Mental Health, Health, Juvenile Probation, and the School District—but no one was centrally responsible for the children.

Mission

- Improve the health, mental health and social functioning of seriously emotionally disturbed children in school, at home, and in the community.
- Maintain SED children in their homes and communities, rather than in out-of-home-placement.
- Develop an effective service network of existing programs and assistance for SED children.
- Create a more cost-efficient and effective system of care by funding flexible services and avoid expensive psychiatric hospitalization and residential placement.
- Promote system change by developing a model of flexible funding and services.

We purchase services we need for each family. We wrap services around the traditional services.

Target Population
Seriously emotionally disturbed children between the ages of three and eighteen who are at imminent risk of out-of-home placement, or are already in an out-of-home placement.

Referral Process
Question: How do SED children reach us? Answer: A wide variety of agencies and individuals call on Family Mosaic to help with this most challenging population.

System Referrals
Mental Health
School District
Juvenile Probation
Child Welfare

Direct Referrals
Private Providers
Pediatricians
Parents
Adult Protective Services.

Intensive Services Committee and Interagency Placement Committee
assess children for eligibility.

We have a Transition Coordinator. Anyone from the community can call the Transition Coordinator and she will help walk the young person and their family through the process, either to get them enrolled with FMP or with other services.

Dr. Dresser: I'm the Evaluator for the Children's Division. I'm a research psychologist by training. It's always a pleasure to do evaluations of FPM because the results are

positive. The questions people have about their programs are always way ahead of the data I've got.

Dr. Moses: How long have you been with FMP? Dr. Dresser: From the beginning. I helped write the first grant. I've been there since before Abner Boles.

Dr. Dresser continued her presentation with overhead slides as follows:

Family Mosaic Project, Summary of Outcomes, 1990-1997

Reduction in Inpatient Hospitalizations and Associated Savings
We looked at the year before the client came into the program—for an average stay of 14 months—and at the year after the program. The average number of hospitalizations goes down dramatically. (Based on 184 FMP clients with hospitalizations.) There is a statistically significant reduction while in the program, and an even greater reduction in the year following the program. The hospitalization figures are 1.3 in the year before, 0.76 during program, and 0.06 in the year after the program. This is very important because we don't often get the long-term picture.

Total Days of Psychiatric Hospitalization Before, During and After Program Involvement
There is a dramatic decrease in the number of days of hospitalization, both during the program and then in the year after the program: from 3,292 in the year before, to 1,659 during the program, to 126 in the year following.

Inpatient Cost Savings
Savings During the Program
3,292 hospital days before program
1,659 hospital days during program

1,633 fewer days in hospital
@ $550 per day
which means of total of $898,150 in savings over 14 months.

Savings over 12 months following the Program
3,292 hospital days before program
125 hospital days after program

3,167 fewer days in hospital
@ $550 per day
which means of total of $1,741,850 in savings over 12 months.

Annual Number of AB 3632 Residential Placements
In 1986 the number of cases were going up, which is one reason FMP was created in 1990. Once the FMP Team was in place, the trend started downward again. The number of placements went from 11 in 1986 to a high of 42 in 1989 and down to 19 in 1996.

Total Days in AB 3632 Residential Treatment
Total days in residential treatment was at a high of 16,294 in 1989 and dropped to 6,255 by 1993.

AB 3632 Residential Cost Savings
Four Years Before Program Inception
11,700 placement days
at a cost of $1,800,877 per year

First Four Years of Program Operation
8,501 placement days
at a cost of $1,308,483 per year

—which means an annual savings of $492,394

Criminal Offenses Before and After Program Involvement
There is a statistically significant reduction, especially in terms of felonies. The average number of offenses per youth before FMP was 1.23. After FMP, the number had dropped to 0.74.

Days in Detention Before and After Program Involvement
Our figures count only days of detention in Youth Guidance Center, not in home detention. The number of days before FMP was 47.67, and after FMP it dropped to 23.97.

Juvenile Detention Cost Savings
Savings During Program Enrollment
17,592 detention days before program
5,734 detention days during program
—
11,858 fewer days in detention @ $239 per day
which means a savings of $2,834,062 over 14 months.

Savings over 12 months Following Program
17,592 detention days before program
4,554 detention days after program
—
13,038 fewer detention days @ $239 per day
which means a savings of $3,116,082 over 12 months.

Summary of Cost Study

Annual Program Costs	
Federal Share	2,336,820
State Match	1,168,410
County Match	1,168,410
Additional County Contribution	467,364
Total	**5,141,004**

Annual Savings	
During Program	3,691,433
After Discharge	5,350,326
Total	**9,041,759**

Parent Satisfaction with FMP Case Management Services
The survey used to measure satisfaction was designed with parent involvement. it was conducted twice and the results were consistent both times. Seventy-five percent of parents were mostly or very satisfied. We built in an option for people less than satisfied so they could get some follow up from the Program Director if they wanted it.

Clinical Implications of FMP Interventions
We asked clinicians to describe the results of FMP:

- More stable and manageable behavior within a wider support network.
- Improved adaptive functioning and coping skills in home, school, and community settings
- Return to autonomous development with opportunities to plan for a constructive future
- Strengthened family connections, trust, and responsibility
- Improved peer relations and positive social activities
- Reduction in negative health and mental health outcomes and lifestyle patterns
- Reduction in criminal victimization

Dr. Beauford: Will you be doing a longitudinal study beyond a year? Dr. Dresser: Yes, we'll keep building the database in future years.

Dr. Moses: I'm glad I finally met someone who was with FMP from the beginning. I remember the first grant from the Robert Wood Johnson Foundation. I thought the grant was supposed to address a particular ethnic group and a particular geographical area. What is the success rate compared to the initial goals?

Dr. Dresser: The program goals were to focus resources in a flexible way to serve SED children in the county who had multiple problems and were at high risk of being placed out of home or who were in out of home placement and would be coming home. FMP was to reduce hospitalization, out-of-home placements, criminal offenses and detentions, reduce client symptoms, improve grades and academic performance, and decrease corollary problems with substance abuse.

Dr. Moses then asked about an independent evaluation. Dr. Dresser: I'm an independent evaluator. I'm hired by the County. I'm not a clinician. I'm not a program director. I'm the independent eye.

Mr. Shipley: How culturally competent is FMP? Dr. Dresser: The ethnic mix and languages spoken are very good. There are a lot of African American clients and a lot of African American staff. We also have Hispanic, Asian, and white staff. We have a good ethnic match to the population being service. It's very telling that the families are satisfied.

Dr. Beauford: Are you tracking families? Dr. Dresser: That's a really good thing to track. I've begun to log them, but haven't gathered data yet.

Peggy Gilleran: What is it that the child is experiencing that is making a difference in their life and creating these outcomes? Dr. Zomalt: It's not only the child, but the family is experiencing for the first time the provider coming in and seeing what they need and then finding services in a way that does not cause distress. Ms. Gilleran: Are you saying that the child's problem is really a family problem. Dr. Zomalt: We see the healing process as a family process. FMP really looks at what the family perceives it needs, educates the family, and brings in the services they need.

Dr. Dresser: Traditional services provide 50 minutes of therapy, and if you match this format you are served well. If not, then you are getting a negative message. We are taking kids with multiple problems, with trouble in school and dealing with issues of poverty. We're going to do everything we can. We're going to be flexible and creative. And we're going to keep working with the client and the family. This is a shift in perspective, a major cultural shift.

Ms. Chan-Sew: What's not quantifiable is the new perception families get of the public system, the trust that FMP builds up. These families had failed so many times before, but after their experience with FMP, if problems come up again, they will feel there is someone to turn to.

Dr. Moses: I want to commend Sai-Ling for the wonderful job you are doing, and especially for covering FMP. I want to welcome Dr. Zomalt and say how important it is to keep the community involved. The Advisory Committee was dying down. Please bring it back to life. Dr. Zomalt: We're meeting on March 24th.

VII. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib reported: We're continuing to work on the Annual Report. Bylaws are being worked on. We have a new committee: Cultural Competency and Special Populations Committee. I'm very excited about that. It can do a lot of good work. All you need to do is decide when you want to meet. The meeting schedule will be every other month.

Please check your calendars and let us know which Tuesday or Thursday in May would be the best for you for the Reception with the members of the Board of Supervisors and the Mayor.

Supervisor Yee's Project Notification Ordinance has qualified for the ballot. The Supervisor is also holding a hearing on children's mental health services on March 26th.

Children's Committee
Dr. Beauford reported as follows: We're working on the Transition Services Meeting which will take place on April 24th. Jeff Mori has agreed to come by for part of the meeting. I'll be meeting with Michele Olson of Supervisor Yee's office about the hearing.

Program and Services
Dr. Shue reported: Evelyn Balancio gave us a presentation about peer counseling. Peer counselors are out at many different programs. David Smith has agreed to be the MHB liaison to the CMHS Peer Counseling Committee.

Consumer/Family Member Task Force
Mr. Leoni reported: We are still in hiatus, working on things. We've had a few moments of drama as we started implementing our rules, but we are moving in the right direction.

Community Advisory Board, San Francisco General Hospital
No report

CMHS Leadership Work Group
No report

VI. PUBLIC COMMENT
Mr. Kalman commented on various issues.

VII. ADJOURNMENT
There being no further business, the meeting was adjourned at 9:21 p.m.

DEPARTMENT OF PUBLIC HEALTH

SAN FRANCISCO MENTAL HEALTH PLAN

LEADERSHIP WORK GROUP

DEPUTY DIRECTOR DMS
JO RUFFIN

MENTAL HEALTH BOARD

FISCAL OPERATIONS
LARRY DOYLE

MANAGEMENT INFORMATION SYSTEM
JOE ABREGO

MEDICAL DIRECTOR
PETER FORSTER

- Access
- Clinic & Facility Psychiatrists
- Pharmacy Services
- Offsite Access Point
- Central Access/ Authorization
- Consultation Services

MANAGED CARE DEVELOPMENT
NANCY PRESSON

- Monitor Risk Management
- Planning
- Contracts/MOUs
- SPRs
- MIS Liaison
- 24-Hour Authorization (Non-Hospital)
- 24-Hour Authorization Hospital
- Interagency Care Management/ Consumer Relations
- Provider Systems

SYSTEM OF CARE
COLLINS MUNNS

- Housing Coordination & Support/Special Programs
- Geriatric Services
- Long-Term Care
- Assessment/Crisis Response
- Child, Youth & Family Services
- Adult Services

QUALITY MANAGEMENT
BILL MCCONNELL

- Quality Management Reviews
- Patients' Rights
- Program Certification
- Program Reviews
- Grievances
- Facility Designation
- Continuing Ed. Units
- Client Satisfaction
- Client Outcomes
- Medical Records Management

CULTURE COMPETENCE & CONSUMER RELATIONS
TINA YEE

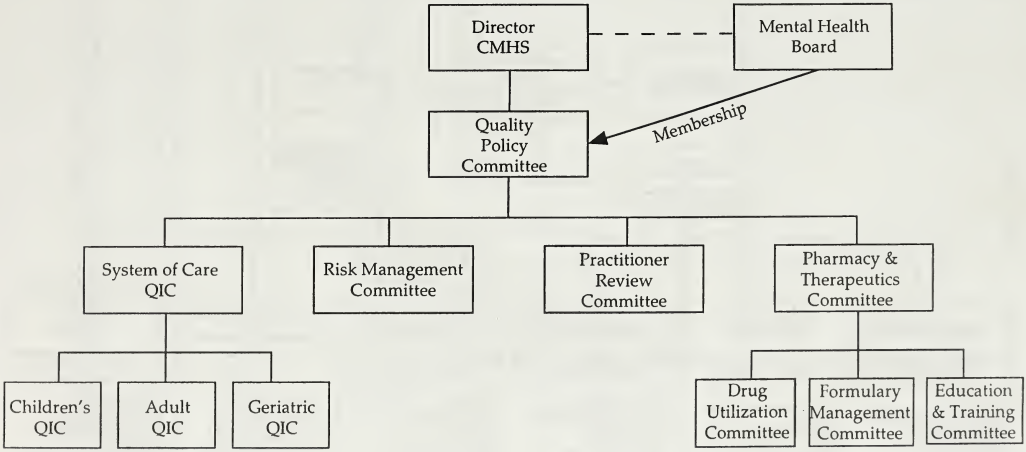
- Information/Advocacy
- Problem Resolution
- Consumer Satisfaction
- Human Resource Development
- Cultural Competence Plan
- Assessing Organizational Capacities
- Training & Consultation
- Public Health Interface
- Community Based Strategies & Collaborations

BUDGET MANAGER
MICHELLE RUGGELS

- Decision Support
- Budget Preparation
- Budget Approval Authority
- Financial & Statistical Reporting
- Performance Management/ Monitoring

QMS: Revised 1/27/98

Quality Management System Operational Chart



SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3751

MEETING OF THE FULL BOARD

Wednesday, April 8, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS

II. CONSENT CALENDAR **5 mins.**
- a. Approval of February, 1998 Minutes
- b. Approval of Requested Leaves of Absence

III. VISIT WITH DR. MITCHELL KATZ: Dr. Katz, new Director of the Health Department, will be present. **30 mins. - Dr. Katz**
15 mins. - Questions

IV. TECHNIQUES FOR WORKING WITH YOUR SUPERVISOR:
April Martin Chartrand **30 mins., including questions**

V. REPORT OF DEPUTY DIRECTOR: Jo Ruffin **15 mins.**

VI. PROPOSED CONSUMER EXCEPTION: ACTION (See Attachment A) **5 mins**

VII. MHB COMMITTEE REPORTS **15 mins.**
- Executive Committee
- Children's Committee
- Program & Services Committee: ACTION Item
  Peer Counseling Standards, Coordination (See Attachment B)
- Cultural Competence/Special Populations
- Other Groups

VIII. PUBLIC COMMENT PERIOD **5 mins.**

IX. ADJOURNMENT

This agenda can be found on the MHB website at
www.ci.sf.ca.us/mental_health

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs, and there is an additional accessible entrance on Grace Alley, to the right of the building. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
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San Francisco, CA 94103
(415) 255-3474
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UNADOPTED MINUTES
Wednesday, April 8, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Mickey Shipley; Sylvia Shue, Ed.D.; David P. Smith; Shawn Thomas; Lora Traveler, M.A.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Chester Villalba

BOARD MEMBERS ABSENT: None.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

PRESENTERS: Mitchell H. Katz, M.D., Director of Public Health

OTHERS PRESENT: Jo Ruffin (CMHS); Collins Munns (CMHS); Emeric Kalman (Family Member); Mike Wise (Consumer/Family Member Task Force); Michael McKinstax; James Kollman (Spiritmenders); Theresa Blomquist (CCSF—Bryant CDP and Elementary School); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS
The meeting was called to order by Maria Leib, Chair, at 6:48 p.m.

II. CONSENT CALENDAR (Postponed until later in the meeting.)

III. VISIT WITH DR. MITCHELL KATZ
Ms. Leib introduced Dr. Katz, the new Director of Public Health, and then asked each Board member to introduce themselves.

Dr. Katz made the following presentation: I was so please to be invited to the recent Violence Prevention Conference. April gave me a brochure you've written about your Board, and I felt it was the best written and best presented that I've seen for our advisory Boards and I plan to send a copy to the other Boards. Your brochure is in language anyone could understand. It's straightforward and clear.

One of the priorities I have, and it was important to Sandra Hernández, is integrating services—recognizing that people need more than one type of service, and I know you all know this.

One of the challenges we're facing is that DPH is set up separately. We have great Mental Health Services under Jo's direction, and great Substance Abuse Services, and great Maternal and Child Health Services. We have great programs, but they are organized separately. People don't come to us in one box, they come as one person. We're organized around funding. When auditors come from the State Mental Health Department, they say, We recognize the client's need for substance abuse services, but we only pay for mental health services. But DPH wants to be organized around what the clients need. We're working on integrating the different services.

We're looking at whether there should be only one advisory board. We're struggling with integrating administratively, but what about the advisory Boards? We want to make our services more coherent to the people who use the services, not to funders, and not our ourselves.

Within the mental health division there is clearly a great deal of unmet need. Clearly we do not have enough services. Your group recognizes this. Jo has been advocating for more services. We recently met with Supervisor Sue Bierman and the Mayor and I think there will be expansions of mental health services starting on July 1st.

It's important to have equal access for people with MediCal and people without. I trained in a system where there were two levels of service and I'm very opposed to that. DPH would do a bone marrow transplant the same way for someone indigent as for someone paying full fee. That's our standard of care. We're facing a situation with the implementation of managed care where MediCal and indigent people would be treated differently, and that just seemed wrong.

The Mayor has expressed support for mental health services on demand, but it will happen over a period of years, not all at once. With Substance Abuse Services, they are opening more and more treatment slots each year as they move into treatment on demand.

Treatment on demand does not mean shorter waiting lists, although that's a good thing. But if you have someone in front of you ready right now for treatment, you want to be able to provide it now. In 3 weeks the person might not be ready. Substance Abuse Services should be expanded to the point where they can offer treatment on demand in another 2 years. For Mental Health Services, it could take 3-5 years.

Mr. Shipley: Studies done at San Francisco General Hospital show that 70-80% of psychiatric patients have substance abuse problems as well. So SFGH formed a task force of about 35 people to work on integrating services. But there are problems because

of the funding coming from different pots. Is there something we can do as the Mental Health Board to help change how these funding streams come to us?

Dr. Katz: The Health Department can lobby the federal government around health programs, and we are working with them on changes. When we are ready to ask for waivers in the future, we may ask for a letter of support from the Mental Health Board. When people are meeting with their Supervisors, we are seeing a lot less single issue lobbying. People are saying: We want more funding for Substance Abuse Services, but not at the expense of Mental Health Services. In many cases it is the same people both services are seeing.

We are looking at General Fund dollars, where we can control the uses of the funds, as dollars that can be use for integration. So, Mickey, there is a lot that can be done.

Ms. Ruffin: An example of integration is where we've located mental health services with substance abuse services in one program. The client doesn't even see that there are two programs. It looks like one program. The State still gets their needs met in terms of their audits.

Dr. Beauford asked about the possibility of reinvesting money saved in Children's Services back into additional programs instead of that money being sent back to the General Fund.

Dr. Katz: Supervisor Yee has introduced a resolution that any dollars saved will go into a Children's Trust Fund for the next year. The way things are structured now is that money saved can be spent on other programs in the same year, but it can't be carried over. But this is not workable. You don't know about savings until April and then what you are going to do? Set up a program for 3 months?

Ms. Planck: We are always told to be more business like. It seems like a reinvestment incentive would be more business like.

Dr. Katz: The Supervisors do not have the right to commit future tax dollars. They cannot promise money beyond the current fiscal year. So that's why anything long-term has to go to the voters. This system is designed to protect our rights as voters. Otherwise, if the Supervisors decided to build a new building, and then there was a change in the make up of the Board, the new Board could vote to discontinue the project, leaving a building half built. That's why we are working on setting up a Children's Trust Fund.

At this point a member of the audience commented: There are lots of people in the psych wards who are warehoused. They are breakfasted and bedded and dinnered, but on a 3-day hold they are never spoken to once by a doctor. Something is seriously lacking in the response of staff at both San Francisco General and St. Luke's.

Ms. Ruffin responded: We do have a Quality Management Program and a grievance process. Anyone can provide us with a letter or a call about such a situation and we can look into it and talk with staff and follow up on it.

Audience member: If we're dealing with mental health, people should have more than bed and food. They should not be treated like rats in cages.

Dr. Katz: You're absolutely right, that should never happen.

Mr. Leoni: Two comments. I'm a veteran of the budget battles of the 80's. Every year there were salary savings and adjustments to the therapeutic model. I had a friend at Westside Lodge Day Treatment who could only talk in group, not one-to-one with a clinician. We may need to look at how programs are being run after years and years of paring down.

My second concern is about managed care. Resources are now being spread thinner over more people. I'm concerned about the people who have historically been on a fee-for-service basis, that they are able to maintain their long-term relationships with their therapists. The federal government seems to be targeting mental health people to get them off the disability rolls, perhaps because a psychiatric disability is the hardest to prove.

Mr. Wise: From your perspective, how is the Rehabilitation Facility doing?

Dr. Katz: I think the R Facility has been a success. It allows people to be closer to their family members. Like any new facility there are bugs to work out in terms of the staffing, the building, and the program. Jo, what do you think?

Ms. Ruffin. I agree. The Board might want to ask for a presentation by staff from the Facility. Julie Peck who has been in charge of managing the flow of clients has some interesting data on the first phase of the R Facility. A surprisingly large number of clients have been able to move into the community. There are definitely lots of issues still to take care of. We've learned a lot, changed some staffing, and are making progress.

Dr. Beauford: In San Francisco to my knowledge, there no psychiatric inpatient services for children under the age of 12.

Dr. Katz: In any medical unit for children, you have to have enough of a volume to be good at it. From what I understand, at Langley-Porter the numbers were so small they couldn't maintain the unit any more. We don't want children to be treated with an adult model. In some ways, it's good there are not more children needing inpatient hospitalization. However, it is a problem and inconvenience for parents to have to go out of the county to visit their children.

Ms. Ruffin added: The average length of stay for the children we admit to inpatient units is 10 days, and we admit about 3 kids per month, so that adds up to only the equivalent of one bed at Langley-Porter. So the inpatient hospitalization program is somewhat a victim of the success of other community-based programs. For example, Child Crisis is a 24-hour a day program which is able to take services right to the home and prevent crises. We also have mental health staff stationed in special education programs. So I hope this loss of the inpatient unit is a reflection of the preventive services paying off. We still have an adolescent inpatient unit at McAuley. The picture starts to change with older adolescents because of the drug involvement which is not happening with the little kids.

Ms. Planck: Is it possible to cooperate with a pediatric unit? Ms. Ruffin: We're having a meeting next week with Pediatrics to see if there's a possibility of doing that for the assessment if not for the ongoing treatment.

Mr. Shipley: Since Langley Porter has shut the children's inpatient service, and other counties are going this way and Napa State Hospital has shut down its unit, families have to move to be near their children. I hope San Francisco does not transfer its long-term children to Metropolitan State Hospital in southern California.

Ms. Leib: As I understand it, children are being sent to Ross Hospital. At least Marin County is not that far away. It's not first choice, but it's a lot better than Del Norte.

Ms. Ruffin: The state hospital system has not provided services for younger children for a number of years. Our plan for adolescents is the Seneca Unit, a long-term locked unit we've put into the Mental Health Rehabilitation Facility

II. CONSENT CALENDAR

RESOLUTION (MHB-98-10): Be it resolved that the minutes of the Mental Health Board meeting of March 11, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-11): Be it resolved that the Mental Health Board grants leaves of absence for the April 8, 1998, meeting to: Peggy Gilleran, Toye Moses, Gloria Samayoa, and Chester Villalba. (Passed)

IV. TECHNIQUES FOR WORKING WITH YOUR SUPERVISOR

Ms. Chartrand made the following presentation. Thank you for allowing me to do this. This presentation is about motivating you to go beyond the call of duty, with regard to our May 5th Reception. I would like you to think about what you have to offer your Supervisor. You might want to get your résumés together. Include your appointment to the Mental Health Board on your résumé. Send this along with a bio and a list of the accomplishments of the MHB prior to meeting with them. Let them know you are looking forward to seeing them on the 5th.

What do you think you would want to do before a meeting with your Supervisor.?

Ms. Traveler: I'm concerned how our Supervisors understand the needs of our mental health clients. I'm interested in how often they get out to hospitals like St. Luke's or St. Mary's or Langley Porter. Often Supervisors are very knowledgeable about AIDS, but we know the needs of the mentally ill. There are still people who can't bring themselves to say the word "schizophrenia." The needs of the mentally ill are shunted, they are very politely address, but the interest is just not there.

Ms. Chartrand: It can be very helpful to think of some of the successes your Supervisor has had. Research their positions. Tie in their interests with your interests. Think about our program reviews and highlight the key points of significant program reviews.

Mr. Shipley. Don't be a phony. My success with people is that I come from my heart. I know I don't please everyone all the time, but that's the nature of human beings.

Dr. Beauford: I think it's important to find out our Supervisor's positions, and find out what they want me to accomplish on the Board, since I'm their appointee.

Ms. Chartrand: It's important to keep in touch throughout the year with letter's and FYI's. I found out my Supervisor's niche. She's interested in domestic violence and workplace violence. So with our combination of interests we were able to have an incredible meeting of the minds. I know she likes art and women's issues. We were in the same magazine in the same week. She returns my phone calls.

Think about what you want to bring to the table on May 5th to have more than casual discussion.

Ms. Traveler: I think it's important to have questions prepared and to hear from our Supervisors what they think. Ms. Leib: Mental health goes everywhere. It's connected to many other issues.

Ms. Chartrand: It would be helpful if Board members sent cards ahead of time personally inviting your Supervisor to the Reception. We have come a long way since I was first on the Board and this is an incredible opportunity to make this a more professional organization.

V. DEPUTY DIRECTOR'S REPORT

Ms. Ruffin: We had a problem with the Access phone system, but we're back up again. On the whole things are going very well with the implementation of managed care. But this is the beginning of a process not the end of a process. Clients who have both Medicare and MediCal do not have to go through us for authorization of their treatment. That information has not gotten out enough. Clients with Medicare and MediCal will still be covered by the State. But those who are seriously mentally ill may come into our service. They have that choice.

We have a grievance procedure, but we are committed to informal problem solving. People can write us or call us and let us know if they haven't gotten the services they needed.

We had a successful hearing on children's mental health run by Supervisor Yee. I want to thank everyone from the Mental Health Board who participated. I think we will get a Children's Trust Fund as a result of this. M. Leib: That was the most cohesive I've ever heard the mental health community be. The hearing ran very smoothly.

Ms. Ruffin: For a long time we have been planning to have a consumer affairs staff under Tina Yee's section. We have had some issue with Civil Service. And we have received two complaints about the job announcement for this position. One was about using the word "affairs" in the title. The other was about the educational requirements. Some people felt the requirements would prevent some consumers from applying for the job. It's a requirement for this level of Civil Service position. The announcement is already out and if it seems to exclude too many qualified consumers we won't fill the position and we'll go back to the drawing board.

I was in Sacramento today for an important meeting. In 1993, mental health funding was "realigned." A bill was passed which gave us a formula for funding, and gave mental health a basis for stable funding outside of the State's General Fund. So we have not had to go back year after year to beg for funding.

Some legislators have decided that it's a good time to take this money, based on vehicle license fees, away from realignment and give it elsewhere. But there was a poison pill in the original bill that said that if you change part of the bill the whole bill will be thrown out.

Ms. Traveler: It appears from a couple experiences I've had recently that when a client goes in to get new medication, the pharmacy has to call in to get it okayed. Sometimes it takes a week. Some pharmacists are giving the clients enough for the weekend until the okay comes through. Ms. Ruffin: I'll follow up on this. In the meantime, if anyone has a question about that, they can still call the Access number at 1-888-246-3333.

Mr. Shipley: What happens when a mental health client comes to San Francisco and needs medications. Ms. Ruffin: Each county has to call the county where the client comes from to get authorization. But the services can be offered here. Mr. Thomas: Access told me that I need to go to Alameda County to get this worked out.

Ms. Ruffin: My understanding is that there should be a way for Alameda County to authorize your services over here. Give me your number and I'll check with Access. You can also call the Access number in your home county and ask them to authorize services. This new system is still rocky. We're learning every day, but these are the things we want to hear about.

VII. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib called attention to Attachment A regarding a proposed change to the State MHB legislation.

RESOLUTION (MHB-98-12): Be it resolved that the San Francisco Mental Health Board communicate to the California Association of Local Mental Health Boards/Commissions that their vote on the consumer exception is:

1) Do not change the section on conflict of interest, but provide that a county having difficulty filling its consumer seats can apply for a waiver of the rule. As part of applying for a waiver, the county would have to demonstrate that it had made a reasonable effort to recruit consumer members who do not work for a mental health contract program;

2) Any members seated under this waiver would be required to abstain from voting on matters that have a direct impact on their employers, and refrain from participating in reviews of the contractor/program where they work. (Passed)

Ms. Leib then called attention to Attachment B, regarding peer counseling coordination and standards, and noted: Peer counseling appears to be a multitude of things and a hodge podge. So this resolution is to create agreed upon standards.

Ms. Traveler. Ms. Balancio made a presentation at the Program and Services Committee. Her peer counseling program was extremely organized and could be a model. We were very impressed with their particular program. Mr. Thomas: I'm very involved in the BUILD Project. In two weeks I begin my training to become a trainer. We're hoping to get a set standard across the boards for peer counselors. Mr. Leoni: I'm concerned about keeping flexibility in standards. Mr. Thomas: We're going to do a directory of peer counselors. Eventually we're going to unionize, we hope. Ms. Planck: Good, the Committee thought that was a good idea.

RESOLUTION (MHB-98-13): Be it resolved that the Mental Health Board recommend to Community Mental Health Services that there be organization and coordination of the various peer counseling efforts being done through San Francisco mental health programs, and that standards be established for performance and training, which would be universally recognized throughout the system. The Mental Health Board further recommends that Community Mental Health Services, in setting these standards, involve, from the beginning, consumers and consumer groups, working in peer counseling and self-help. (Passed)

Ms. Leib reported that the Annual Report on the mental health system is at the printers. She said the By-law revision is in progress. She congratulated the Board for accomplishing everything it set out to do last fall.

Children's Committee
Dr. Beauford reported on the Transition Services Meeting scheduled for April 24th.

Committee on a Cultural Competency and Special Populations
Ms. Chartrand reported: We talked about what we had to offer and picked areas of focus: April—women, domestic violence; Sylvia—languages; Chet—poverty, homelessness; Toye—criminal justice.

Our next meeting will be a viewing of the film "The Color of Fear," which deals with racism. We also have a mission statement we'd like to talk about next time, and we'll need to choose a chair for the committee.

Ms. Planck: The Committee will meet once a month for a while, instead of every other month. Each member will take an area of interest and will report to the Committee.

Community Advisory Board, San Francisco General Hospital
Mr. Shipley reported: At the meeting last night we had a report from the Department of Psychiatry dealing with AWOL issues, and a report on cultural competency and spirituality.

CMHS Committee on a Culturally Competent System of Care
Ms. Chartrand reported: We reviewed the outcomes forms. We also reviewed the African American Mental Health Conference. There were some problems with it. Some of the speakers needed more clinical information. Perhaps better screening would help next time. They may be good care givers, but not ready to be speakers.

VIII. PUBLIC COMMENT
Ms. Blomquist introduced herself as a parent of two disabled children. She is working with the Family Resource Center, with Christmas in April to build a center on the Phelan Campus, and serves on the District Policy Advisory Committee for the Child Development Centers of the San Francisco Unified School District. She made the following comments: I would like to see assessments being done earlier. I would like to see more CMHS involvement in the elementary schools. The parents are reaching out for resources and with the consolidation happening here, you really have to let them know what you have to offer. I'd be glad to help get the word out.

Mr. Leoni: I really hope the Board does follow through on the realignment threat that Jo discussed.

Mr. Herman: I want to address an issue of major concern to myself and the community at large—Attention Deficit Disorder. I've been involved in CHADD, Children and Adults with Attention Deficit Disorder. When someone becomes an adult there is nowhere to go to get services, particularly if you are indigent. The DSM IV recognizes ADD, but if you go to San Francisco General Hospital, you can't get treated for ADD. The 1973 Rehabilitation Act says that there is supposed to be access to treatment for people with disabilities and ADD is a disability. Children can get treated but not adults.

A Special Prosecutor at the District Attorney's office has said that 75% of people incarcerated have ADD. And they don't have a way of dealing with this. It costs $50,000 to incarcerate one person for a year. For that, we could heal a whole community of people using new treatments and technology. I would like to see official recognition of ADD as a disability that needs to be treated in the community. It's just not fair to not offer treatment.

I'd be glad to follow up with you in any way I can to help get official recognition, so there is no discrimination against people with ADD, whether advertent or inadvertent.

Ms. Leib: We will certainly study this and follow up on it.

Mr. Kalman brought up the following: Why is there no public input after each agenda item? Why not change the date of your Reception for the Supervisors to Monday afternoon May 4th when they will all be in City Hall? I asked Supervisor Bierman to send one of her aides to our meeting. I think the public comment time should be at the beginning of the meeting.

Mr. Leoni: I think there should be public comment before any vote taken.

IX. ADJOURNMENT
There being no further business, the meeting was adjourned at 9:35 p.m.

0.52

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

Suite 510
1380 Howard Street
San Francisco, CA 94103
(415) 255-3474
fax: (415) 255-3760

PUBLIC NOTICE

The Mental Health Board of San Francisco has invited the Mayor , the members of the Board of Supervisors, and the staff of each of the Supervisors to attend a Reception on Tuesday, May 5th, from 3:30-6:30 p.m. in Room 207, City Hall at 401 Van Ness Avenue.

A quorum of the Mental Health Board will be present, however no business will be considered and no votes will be taken. It is possible, but not likely, that a quorum of the Board of Supervisors may be present for a few moments during the Reception.

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www.ci.sf.ca.us/mental_health

MEETING OF THE FULL BOARD

Wednesday, May 13, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS (5 minutes)

II. CONSENT CALENDAR (5 minutes)
a. Approval of April, 1998 Minutes
b. Approval of Requested Leaves of Absence

III. SPECIAL PRESENTATION **by Supervisor Leland Yee** on Reinvesting Money Saved by DPH and Blended Funding, two Resolutions for enhancing funding for Children's Services. See Attachment A. (40 minutes plus 15 minutes for questions).

Brief Recess: 5 minutes

IV. MHB COMMITTEE REPORTS (35 minutes)
- Report of Chair, Status of Plans for May 6 Reception
- Executive Committee
- Children's Committee
- Program & Services Committee
- Cultural Competence/Special Populations Committee
- Other Groups
  - Consumer/Family Member Task Force
  - SFGH CAB
  - CMHS Committees

V. PUBLIC COMMENT PERIOD (15 minutes)

VI. ADJOURNMENT

This agenda can also be found at:
www.ci.sf.ca.us/mental_health

SUNSHINE ORDINANCE

(Chapter 67 of the San Francisco Administrative Code)

Government's duty is to serve the public, reaching its decisions in full view of the public.

Commissions, boards, councils and other agencies of the City and County exists to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review.

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UNADOPTED MINUTES
Wednesday, May 13, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Peggy Gilleran, J.D. (Acting Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler, M.A.

BOARD MEMBERS ON LEAVE: Supervisor Sue Bierman; Maria Leib (Chair); Shawn Thomas; Chester Villalba.

BOARD MEMBERS ABSENT: David P. Smith.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

PRESENTERS: Supervisor Leland Yee, Michele Olson (Staff to Supervisor Yee); Sai-Ling Chan-Sew (CMHS).

OTHERS PRESENT: Collins Munns (CMHS); Rinna Flohr (CMHS); Tim Agar (Glide Health Center); Yuwen Liao (USCF); Shelley Parker (UCSF); Emeric Kalman (Family Member); Mike Wise (Consumer/Family Member Task Force); Mark Adamek (SF Network of Mental Health Clients, SF Depressive/Manic Depressive Association, SFGH Department of Psychiatry Community Advisory Board); Carl Word (California Institute for Integral Studies); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Peggy Gilleran, Acting Chair, at 6:35 p.m.

II. CONSENT CALENDAR (Postponed until later in the meeting.)

RESOLUTION (MHB-98-14): Be it resolved that the minutes of the Mental Health Board meeting of April 8, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-15): Be it resolved that the Mental Health Board grants leaves of absence for the May 13, 1998, meeting to: Maria Leib, Shawn Thomas, and Chester Villalba. (Passed)

Ms. Gilleran then read the following newly-revised statement on how the public can take concerns and issues to the Mental Health Board. She pointed out the new system of public comment cards that were on the desk by the door, so people could submit written comments as well as addressing the Board directly during the public comment time during the Board meeting.

PUBLIC COMMENT
TO THE MENTAL HEALTH BOARD

The Mental Health Board (MHB) welcomes your comments and recommendations, and we have listed below some of the ways to give them to us. Remember, however, that the law does not allow the MHB to make instant decisions. Like the Board of Supervisors, it works through Committees, which review and analyze issues and then send them as Resolutions to the Full Board.

The MHB does its best to respond to issues raised during Public Comment Period, but they cannot act immediately. Resolutions must go through the Committee process and adequate public notice must be given before the Board can act (vote).

AT A MEETING

•**Public Comment Period at The Full Board:** You can speak directly to the Full MHB during the Public Comment Period. Near the end of every meeting, there is time on the agenda for comments from the public. Please note that this is a limited period of time. The amount of time each individual will have is decided by the MHB Chair, depending on how much time there is and how many people want to speak. Sometimes people are given 3 minutes to speak; other times only 1 minute.

•**Following a Presentation:** When there is an outside presentation, comments and questions from MHB members will be taken first; then, at the discretion of the Chair and depending on time available, the public may comment or ask questions.

•**Public Comment Cards** are available at Full MHB meetings. You can write down your concerns and drop them in the Comment Box.

•**A Committee Meeting:** If you would rather comment in person, staff can arrange for you to come to a meeting of the appropriate Committee.

OTHER WAYS TO COMMUNICATE WITH US

Write a letter, e-mail us, or call. The address and numbers are at the top of this page.

•If you write, you can explain your ideas or recommendations as fully as you want, and you can enclose documents or clippings.

•On the phone, our staff can help you decide which way of submitting comments to the Board might work best for you.

•You can also visit our web site and e-mail us directly from the web site link.

III. SPECIAL PRESENTATION by Supervisor Leland Yee
Ms. Gilleran introduced Supervisor Yee as follows: Supervisor Yee was elected to the Board of Supervisors in 1997. Prior to that he was on the Board of the San Francisco Unified School District, where he served as Vice President and then President. He has a doctorate in clinical psychology and his special area of interest is children.

Supervisor Yee made the following presentation: I really appreciate the time you're giving me. I'd like to introduce Michele Olson, my Chief of Staff and the person in my office who handles health care issues.

I want to talk to you about an issue that's very important to me. Children don't have a strong voice, so they get the short end of the stick. I'm coming to you with a proposal for increasing the funding for children's services. I want to pull together children's agencies and the school district in a collaborative way to identify what services are being provided which could draw down more reimbursement from the federal government, and then put those new reimbursements into a Reinvestment Fund. This is a proposal the staff has come up with that I will take leadership on at the Board of Supervisors.

What we want to do is keep moving toward the least restrictive environment for children and youth in terms of their treatment. Whenever you provide dollars in a more restrictive environment, such as hospitalization, it tends to be more costly. So if the staff is moving young people to less restrictive environments, can the savings from that effort be reinvested into children's services, not only for mental health but for many other departments serving children? Can we use this process to maximize the use of our funds? Such savings could also go into the Reinvestment Fund.

I remember when I worked in CMHS years ago. There was a potent treatment concept started by Sai-Ling Chan-Sew and her colleagues at the Chinatown Child Development Center. Parents would bring their children to the mental health center, but it wouldn't be seen as that. Mental health professionals would assess children in a childcare setting, a culturally-sensitive and unintrusive setting, so parents were willing to bring their children in. This was unheard of in those days, to go to the mental health clinic. It allowed us to identify children who needed help.

We want to use the Reinvestment Fund for such prevention services and to deal with unmet needs. This will not be the whole answer, only part of the answer. It's designed to maximize the use of the dollars we have. If you would support this initiative, we'd be most appreciative. It is scheduled to be heard on May 27th at 1 p.m. at the Finance Committee of the Board of Supervisors. Representation from this Board at that hearing would be appropriate and appreciated.

Ms. Traveler: Thank you, Supervisor Yee, for your explanation. When we're talking about leveraging existing dollars and we want to pool all the money in a collaborative way, what kind of problems do you perceive in that, given that all those programs are

in need of money. Why would they want to do this? How could we be assured that mental health programs would get their fair share?

Ms. Chan-Sew responded: California is 49th among all the states in claiming MediCal reimbursements, so if a school has a counselor providing mental health services, we can't bill the federal government. But if we could certify that counselor as a mental health professional, then we could bill the government and bring in money for those services. Fifty-cents of every dollar would go to the fund for prevention. Fifty cents of every dollar would be used to expand direct services. But we also need to provide prevention services because without that the need for services will just keep growing.

Ms. Traveler: What programs will you be changing to provide the least restrictive plan?

Supervisor Yee: You'll clearly have some children needing hospitalization and that's expensive. But if the plan can be developed to serve that child in a less restrictive environment then money will be saved. Then those saved dollars can be put into the Reinvestment Fund.

Ms. Traveler: Would it take about 5-10 years to do this? Supervisor Yee: We're looking at about 5 years to get this really moving. Ms. Traveler: What about a direct approach to the Governor? Supervisor Yee: The legislature is still working out with the Governor what the budget will be. They are working on sending more money from the State to the Counties. Sue Bierman is working on getting more funding for mental health.

Dr. Moses: Supervisor Yee, I want to commend you for what you are doing for youth in San Francisco. One group not getting enough attention is teen fathers. I think we should always remember not just the kids who are getting pregnant but the ones who are getting them pregnant. Supervisor Yee: Yes, we'll include them in the services.

Supervisor Yee continued: We need your help with this proposal. This will be a cultural change in how things are done. Children in this city have not gotten adequate services and this is an attempt to respond to that.

Dr. Beauford: I also want to commend you on the work you've been doing on behalf of children's mental health services. One of the agencies involved is the School District. How receptive are they? Relations with them have often been tenuous.

Supervisor Yee: I haven't yet talked with them, but Sai-Ling has. I will be meeting with the Finance Director of the School District and will be talking with the Superintendent. I hope my years on the School Board will help in this process.

This proposal is not asking for new money from the City. It's about existing dollars and how to maximize them. It's about getting proper reimbursement for work that's already being done. If there is any opposition, we'll need your help.

Dr. Shue: Are there other areas beside school counseling where the reimbursement part of the proposal would apply? Ms. Chan-Sew: Yes, the services offered after a young person leaves YGC is another example. When the young person goes to a shelter for a short time there are counseling services there that could be billed for and then in turn the services could be expanded with that new money. In DHS shelters they do a lot of crisis intervention and counseling. If those services are provided by qualified mental health professionals, then we can bill the state.

Dr. Shue: So this is not taking anything away, but identifying what is already going on. Ms. Chan-Sew: Yes. Supervisor Yee: One reason the School Department might be hesitant is that if we bring in this additional money, they might be concerned about how much of it they as the School District will get.

Ms. Chan-Sew: We have an interagency group meeting and working on this very problem. Many of the counselors we have are not licensed professionals. But where we do have licensed clinical psychologists, there we can do billing.

Ms. Gilleran: I have two questions. 1) I've had experience working with Special Education specialists around children with mental health problems, and I've been very disappointed. They don't seem to have training on how to work with these children. I would want to see specialists in Special Education who could work with these children effectively.

2) There's been a trend in recent years to focus more on medication than on staff doing therapy with the children. But children with severe mental illness don't just need medication but therapy as well to prevent them from developing lifelong mental illness.

Supervisor Yee: I couldn't agree with you more. The state of the art right now is in drug treatment rather than therapy. With regard to Special Education, Sai-Ling and before her, Nancy Pression, have been working with Special Education on helping them work with mental health issues in a better way. I think the direction to go in is to locate mental health services with school services.

Mr. Shipley: I appreciate your bringing this to our attention and coming and asking us for help and working with Sai-Ling on this, because children are our future. There are a lot of people with mental illness who with the right help are very functional and capable. It's also important to give more attention to our transition services for young people transitioning into adulthood. Supervisor Yee: I held a hearing on children's mental health recently and that came through loud and clear.

Ms. Traveler: I'm very interested in this proposal, though I do know some of the pitfalls. People providing services are already operating at the maximum of what they have. The issue is collaboration. You want people to come together instead of being off in their own little boxes, then they'll get more money for the services. Ms. Chan-Sew:

You're really right. We need all the providers to support this so it doesn't seem to be just more work. If they don't see the benefits, then they won't support it.

Supervisor Yee: With schools, we're looking at services they are providing that are mental health type services. If we can get people who are licensed in those positions then for people who are on MediCal, those services are billable. Dr. Shue: I want to reiterate the concern that when the money gets divided up, mental health doesn't get the short end of the pie.

Mr. Leoni: Since all mental health money comes down through the mental health carve out, this funding we're talking about would be through Early Periodic Screening Diagnosis and Treatment (EPSDT) fund, wouldn't it? Ms. Chan-Sew: Right. EPSDT funding is not capped. Mr. Leoni: The Mayor's Blue Ribbon Commission has talked about blended funding and you need a HCFA waiver for that. Is this the same? Ms. Chan-Sew: This is separate. Los Angeles County has been doing blended funding for 5 years. If the school counselor certifies the services as mental health service, then it is billable. All that's needed is an inter-departmental MOU.

Mr. Kalman: The biggest problem in any service is money. My understanding is that Supervisor Yee wants to establish a fund for more services for children, especially prevention services. Do you have a figure on what are the critical unmet needs in what you are proposing and an expectation of how much additional money will come in? Supervisor Yee: We don't have calculations on how much money would come in savings.

Mr. Wise: Is there any prioritizing of state managed care dollars going to the programs you're talking about? Ms. Chan-Sew: Basically the managed care plan is for treating people with diagnosable mental illness. With other services the same thing is true—you have to have a problem first before you get treatment, you have to beat up your child or you have to commit a crime. But very few funding streams give you the money to prevent mental illness or prevent other problems. This idea is to stop the problems earlier, so we don't have so many people needing to have direct services.

Mr. Wise: What about the involvement of the schools in this? Supervisor Yee: That's a problem organizationally. The School District exists separately from the City and County. They are a creation of the State Education Code. They are not part of the City Charter. We do have some leverage, but not a lot.

IV. MHB COMMITTEE REPORTS

Executive Committee

Ms. Gilleran: Maria Leib was so disappointed to be sick tonight. She wanted to personally be able to tell you how she felt about the Reception with the Mayor and the Supervisors and their staff.

Her message is: Bravo! Bravo! Bravo! The Reception was a resounding success. The Mayor, 7 Supervisors, and 17 staff attended, along with Jo, Collins, Sai-Ling and 12 members of the Mental Health Board. We've heard great feedback from everyone we've talked to.

Ms. Gilleran continued: We are currently looking for an alternate representative to the California Association of Local Mental Health Boards and Commissions. We have two vacancies on the Board for Family Members and one for a Mental Health Professional. Also there is an opening for an MHB liaison to the Pharmaceuticals and Medical Committee of CMHS.

Children's Committee
Dr. Beauford; The Transition Services Meeting on April 24th went very well. At the next meeting of the Children's Committee we'll be setting new directions for the next year of work. Ms. Samayoa: The Transition Services Meeting had a very good turn out. The facilitator did a good job of running the meeting. Everyone agreed to follow up on what was accomplished. Dr. Beauford: The Transition Services Web Site was something everyone was excited about. I think that's going to have longevity and will be one of the best things to come out of the meeting.

Program and Services Committee
Dr. Shue: At our last meeting we heard from Mobile Crisis, Roy Crew of the Office of Self Help, Sidney Lam from Residential Care, and Jane Kahan of the Mental Health Association. Ms. Gilleran: It was a very constructive meeting. We learned a lot and shared a lot.

Committee on a Cultural Competency and Special Populations
Ms. Samayoa: We saw the film "The Color of Fear," which is about a group of people who talked about how they experienced racism. The theme was how you can work on your racism and talk to people about racism. Ms. Planck: Gloria and Chet were picked as co-chairs of the Committee.

CMHS Committee on a Culturally Competent System of Care
Ms. Chartrand: The Committee looked at a cultural competency form from the State. We wrote a letter in response asking if the State is only going to look at language issues, and then gave them some other issues which we felt were part of cultural competency. We have to put the questions on the form that the State requires, but we are allowed to add other things we want to add to the form we'll use in San Francisco.

Consumer/Family Member Task Force
We're continuing to meet. In our next meeting we'll be working on the Handbook which incorporates our guiding principles and serves as our window to the world to let people know what we're about.

SFGH Community Advisory Board
Mr. Shipley reviewed the agenda of the meeting, which included: A report from Mark Leary, discussion of patient grievances, the Community Outreach Committee report, and the welcoming of Mark Fisher as a new member of the CAB. Mr. Shipley announced that there will be a bake sale for the clothing project so they can buy socks, underwear, and shoes for people on the inpatient unity and in the Community Focus program. He continued: Many of the people who come in to the inpatient units are homeless or live in SRO's and the landlord throws out their possessions while they are in the hospital.

Ms. Gilleran: I want to make a special plug for the clothing fund. You can imagine what it would be like to leave the hospital with no clothing. I know it happens. Next time you've got clothing to donate to Goodwill, you can direct your goodwill to SFGH. Mr. Shipley added that to make donations people can call Amelia Truman at 206-8413.

CMHS Outcomes Committee
Mr. Shipley: I attended the meeting of the Western States Regional Data Collection Group and made a presentation on outcomes and how important they are not only to the State and Counties, but also to consumers. I said that consumers need to be educated about outcomes. My presentation was well received. Steve Leoni also presented at the meeting.

V. PUBLIC COMMENT
Mr. Kalman: First, I would like to ask the Board about the Continuum of Care for the Housing of the Homeless. As we all know, homelessness may be the product of mental illness, or if you become homeless, you may break down and become mentally ill. Is the mental health community involved in this process. There is very little in the Continuum plan about mental health needs.

Second, we see in the press probably weekly, serious violent acts committed by people with mental illness. For example, a man with serious illness stabbed 3 people on Market Street. There was a letter in the Examiner which questioned the spin the reporters put on different incidents. In this incident, it was that a "homeless man" committed an act of violence. But in the case of the 101 California Street situation, they didn't say a "homeowner" committed the violence. I think there should be follow up on this kind of spin. It all adds to stigma and fear.

Ms. Gilleran: Everyone on this Board shares that feeling with you. The National Alliance for the Mentally Ill (NAMI) and the California Alliance for the Mentally Ill (CAMI) work specifically on ending stigma.

VI. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:23 p.m.

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MEETING OF THE FULL BOARD

Wednesday, June 10, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS — **5 mins**

II. CONSENT CALENDAR — **5 mins.**
- a. Approval of May, 1998 Minutes
- b. Approval of Requested Leaves of Absence

III. PATH GRANT SUBMISSION : Ratify Executive Committee Action — **15 mins**
- a. Letter endorsing CMHS Grant submission
- b. Letter to CMHS re: Notification of MHB

See Attachment A

IV. DISCUSSION OF LAST MONTH'S PRESENTATION; Report — **15 mins**
On Status of Re-Investment Proposal

V. REPORT OF CMHS DIRECTOR Jo Ruffin: To Include Latest — **35 mins**
On Budget. Discussion of Mental Health Budget.

VI. MHB BUSINESS, COMMITTEE REPORTS — **40 mins**
- Report of the Chair
- Executive Committee ACTION: Bylaws Revision. See Attachment B
  ACTION: Cancel August MHB Meeting?
- Children's Committee
- Cultural Competence/Special Populations
- Program & Services Committee
- Consumer/Family Member Task Force
  - CMHS Committees
  - SFGH CAB

VII. PUBLIC COMMENT PERIOD — **5 mins.**

VIII. ADJOURNMENT

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UNADOPTED MINUTES

Wednesday, June 10, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Tim Agar; Jim E. Beauford, Ph.D.; Millicent Bogert representing Supervisor Sue Bierman; April Martin Chartrand; Darwin Dias; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Mickey Shipley; Sylvia Shue, Ed.D.; Shawn Thomas; Chester Villalba

BOARD MEMBERS ON LEAVE: Gloria Samayoa; Lora Traveler, M.A.

BOARD MEMBERS ABSENT: David P. Smith.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

OTHERS PRESENT: Jo Ruffin (CMHS); Jennifer Friedenbach (Coalition on Homelessness); David Page (Mission Family Center); Emeric Kalman (Family Member); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:34 p.m.

II. REPORT OF THE CMHS DIRECTOR

Jo Ruffin reported on the budget for mental health services for fiscal year 1998/99 as follows: The Departments have all submitted their proposed budgets to the Mayor's Office. The Mayor's Office has reviewed those proposals and has come up with the Mayor's proposed budget which has been sent to the Board of Supervisors. The Board of Supervisors will be holding hearings next week.

The San Francisco Mental Health Plan started up on April 1, 1998. Under that Plan, San Francisco has to provide benefits to MediCal beneficiaries. We've requested additional funding to expand the same benefits to the indigent population. The Department of Public Health adopted it as policy to provide a single standard of care. We started implementing a single standard of care on April 1st, so we have a couple months of experience.

The Mayor's Office allocated $1 million for the single standard of care in the Mayor's budget proposal. That's less than what our single standard of care will cost.

Ms. Ruffin then provided a handout summarizing the first two months of experience with the single standard of care, and continued her report as follows: What we're estimating is that we'll need an additional $4.6 million on top of the $1 million already allocated.

The eligibility for services under the San Francisco Mental Health Plan is as follows:

Payor	Safety-net for SMI/SED[1]	Expanded[2]
SF MediCal 104,000 eligibles	14,450 estimated users	3,700 estimated users
SF General Assistance and homeless 18,000 eligibles	2160 estimated users	750 estimated users
Child 200% of federal poverty level (Healthy Families) 6,000 eligibles	120 estimated users	250 estimated users
All other uninsured 106,000 eligibles	6,250 estimated users includes the under-insured	uncovered: 4,200 estimated users
Under-insured[3] for mental health 530,705 eligibles		covered through their own insurance

[1]Safety-net benefit includes the full range of rehabilitation/case management services for individuals who are seriously mentally ill/seriously emotionally disturbed (SMI/SED). We expect to be able to cover the individuals in these categories as we always have without incurring a deficit.

[2]Expanded benefit includes appropriate treatment for individuals who are not SMI/SED but who have a DSM IV diagnosis and either a significant impairment in life functioning or a probability of significant deterioration. We are required to offer this expanded benefit to MediCal beneficiaries. We project that with our $1,000,000 allocation we can offer this benefit along with associated medications to General Assistance beneficiaries, homeless, and children 200% of the federal poverty level.

[3]Coverage of under-insured individuals would be limited to those who are seriously mentally ill/seriously emotionally disturbed, who require safety-net services and whose mental health benefit does not over the services they need. To confirm this, we would require the insurer to initiate referrals. We would work with the large insurers to assure they provide the benefit they have contracted to provide, and to clarify their role in the interface and referral process to our safety-net services.

With $1 million, we'd recommend serving down to row #2 in the chart. There are currently 2,500 homeless people in the mental health system, and we are estimating another 750 coming in. The next priority would be row #3, the services for children.

That would leave just the safety net services for the other 106,000 eligibles. The last group is the under-insured clients. If you have health insurance at all, still you are probably under-insured for mental illness. For years we've had people in the system who have coverage but are underinsured for mental health. Where we do identify people with coverage, we are referring them back to their own health plan and we are working with those plans to provide coverage when they feel the person needs more services than they can provide. We want to see the health plans stay involved in providing the services to their clients which they should be providing. Currently we have 1,635 Kaiser members in our system and are providing them with $2 million of services. Since they are in our system, Kaiser has not had to be responsible for outpatient and medication services. Our new proposal would involve them in providing care.

With regard to other issues you've been interested in, the Department of Public Health requested a 3% COLA for contract programs. We will probably receive some COLA for residential facilities in mental health and substance abuse services, but not an across the Board COLA.

Mr. Villalba: What's the cost of living increase for City employees? Ms. Ruffin: There's not an across-the-board increase; it varies by union. I don't have the numbers on that. The contractors have spoken with the Board of Supervisors. Last year there was no COLA, but $1 million was allocated for an incentive fund for contractors and that will be continued. Ms. Planck: With regard to the San Francisco Mental Health Contractors Association, one of their issues over the years has been parity with City employees. Ms. Ruffin: A number of nonprofits are unionized and more of them have been unionized over the past year.

Ms. Gilleran: It concerns me that we are permitting an insurer to set criteria for making a referral to us. For example, a client who is stabilized and in therapy, but refuses to stop therapy and only take medication can be denied services by their insurer. So it worries me to allow them to make the referral. Ms. Ruffin: I appreciate that feedback. The idea is not to put another hoop up for the client. We need to put in place an agreement with the health plan about how referrals will work.

Ms. Gilleran: The insurer's motivation is to make a profit. Ms. Ruffin: It's a problem when we're trying to provide coverage to people who have no insurance and some people don't tell us that they do have insurance. Ms. Gilleran: I understand that. Ms. Ruffin: I appreciate your comment.

Dr. Moses asked about expanding acupuncture treatment in the system such as the program at Bayview Hunters Point. Ms. Ruffin: We do provide acupuncture on a limited basis. We did not put a proposal in for expanding it, not because we don't support it, but because we were so concerned about the single system of care.

Mr. Agar: Jo, thanks for this information. Historically you're referring to a deficit. Does that mean that CMHS has operated under a deficit in the past? Ms. Ruffin: No, we've done fairly well at balancing the budget in the past. Over the past 3 years we've become the San Francisco Mental Health Plan. Three years ago we consolidated inpatient services. On April 1st of this year we consolidated outpatient services. The State gives us a fixed allocation based on 1993 expenses, so we know this is an under-allocation. So we're starting out in the hole. No county received money to provide services to non-MediCal people. This county was trying to find the money to do so. We're not currently in deficit, but we will have to limit the authorization of services in the coming year in order not to end up in a deficit.

Ms. Leib: Are you expecting referrals to level off or do you think they will continue at the current rate? Ms. Ruffin: It hasn't leveled off yet. What I've presented to you in the handout is a one-year project. The requests for services coming through ACCESS are running at 75-100 calls per day. And that's without outreach which we have to do under the State guidelines. Our caseload used to be 60% MediCal and 40% indigent. Now it is the reverse: 40% MediCal and 60% indigent.

Mr. Shipley: With regard the expanded estimate of 750 homeless families, that is a serious under-estimation. Ms. Ruffin: Yes, that is an under-estimate. We do have homeless people in the system, but once they are in we do everything we can to get them into housing. Mr. Shipley: The research data I've seen from Caduceus, the Homeless Coalition, and Swords to Plowshares, shows that the numbers are much higher than what is estimated here. Our Health Commission and the Board of Supervisors are committed to expanding services. They know there is a need, but the Mayor doesn't seem to be listening to that. He wants to put more money into protocol.

Ms. Ruffin: I'll go back to my staff for more clarification on how they got the estimates. The original estimates we took with the Homeless Coalition to the Mayor's office were higher.

Dr. Shue asked about the cost analysis of traditional treatment as opposed to alternative treatment, and said that it was important to find funds for alternative treatment. Ms. Ruffin: The managed care system requires that we pick up the existing system at the same rates they were paying. There is not enough money to pay more. And the State

wasn't covering alternative services. Ms. Leib: I don't think they're going to cover alternatives when they would fully cover the basics.

Ms. Ruffin: We asked for money for the newer antipsychotic medications for the uninsured and that was not funded in the budget. But were are not pulling back from that. There are cost effectiveness studies that show the value of the new medications. We've done a lot of work on creating new ways of serving people, such as wrap around programs, case management, single point of responsibility programs. Those pilots are in progress and we'll be evaluating them.

Dr. Shue: I'm terrified listening to Mickey talk about the numbers and then there is a reduction of SSI that may be coming. Did you include in your proposal the effects of the Reinvestment Proposal from Supervisor Yee? Ms. Ruffin: Our proposal hasn't included that so far. The Children's Services are leveraging federal dollars, but this uninsured population is not eligible for those dollars, so it wouldn't cover them. We're hoping to work with the Department of Human Services to try to deliver services more effectively.

Mr. Shipley: If the expanded numbers go beyond 750 would that mean that more people would be turned down for services? Ms. Ruffin: What I hope would happen is that we continue to monitor daily authorizations, and if that happened, we'd go to DPH to see if we could find some ways to cover the expanded number of people. Ultimately it could happen that we'd have to say that we're out of money. But I hope it doesn't come to that. Mr. Shipley: Would that put us out of compliance with the State? Ms. Ruffin: The State only covers MediCal clients, so they don't care about the indigent population.

Dr. Beauford: Have you started discussion with health plans? I'm concerned about referring people back. Some of them can't afford the services from their own health plans. The clients will get caught in the middle. Ms. Ruffin: This is the second announcement of our plan for working with health plans. Last night it was presented to the CMHS Executive Committee, and I also wanted you to hear it tonight.

In the past months we've heard of insurers saying to their members: If you don't like what we're doing for you, you can go to the County for services. But it's not okay for the private insurers to dump their members on the County. We're telling them, You take premiums to provide services to your members, and we expect you to do that. And we're quite willing to provide the safety net for the seriously mentally ill.

I hear what you and Peggy are saying. We've had two months experience now with ACCESS and have some specific situations that we are ready to talk with health plans about. But we are ready and willing to help these plans figure out their services. It's not cost effective not to treat people. The studies show this.

Ms. Gilleran: The insurers will only pay if the person has a psychotic episode instead of preventing the episode. They just don't have insight. Ms. Ruffin: We're proposing to continue our safety net services, such as crisis services, emergency care, and

assessments, no matter what a person's status is. But we want to say to the health plans: You have an obligation to pay us to do, or else you should provide the services.

DPH and the Health Commission do not want to back off from the single standard of care, even if it takes several years.

Mr. Villalba: I think it's important for the Mental Health Board to remind the Board of Supervisors about their commitment to a single standard. The budget cut will not support that. Further, it's important to let them know that the numbers estimated are too low an estimate.

Mr. Leoni: I want to remind everyone that you have the power as the Mental Health Board to advocate in a way that CMHS can't. Their hands are kind of tied.

Ms. Friedenbach: Thank you for giving me a chance to speak. I'm with the Substance Abuse/Mental Health Work Group of the Coalition on Homelessness. We have a real big problem here. From the Department's own estimates there are 5,000 people without insurance who will need services. One million dollars will pay for 1,000 people. We're talking about people on General Assistance and people who are homeless. The GA system has historically discontinued people with mental illness. There have been huge discontinuances. There are 4,000 people on GA, there are 5-7,000 homeless mentally ill. So an estimate of 750 will not cut it.

The estimates are way too low. My fear is that arbitrary boxes are being created to fit people into to get treatment. We'll go way above the 750 expanded slots. We're going to do some massive outreach. We urge you to take this seriously and put pressure on the Supervisors and come out to the hearing.

III. CONSENT CALENDAR

RESOLUTION (MHB-98-16): Be it resolved that the minutes of the Mental Health Board meeting of May 13, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-17): Be it resolved that the Mental Health Board grants leaves of absence for the June 10, 1998, meeting to: Gloria Samayoa and Lora Traveler. (Passed)

IV. PATH GRANT SUBMISSION

RESOLUTION (MHB-98-18): Be it resolved that the Mental Health Board ratifies the action of the Executive Committee in:

a. Endorsing the 1998-99 application by Community Mental Health Services for PATH funds, and

b. Communicating to CMHS that, in the future, the Mental Health Board will reserve such action for actual emergencies; for non-emergencies like re-

applications and continuing grants, we will require that they submit to the full MHB a draft and a report on outcomes from the previous year's grants, in time for the MHB to make an informed response. (Passed)

V. DISCUSSION OF LAST MONTH'S PRESENTATION ON THE REINVESTMENT PROPOSAL

The proposal was continued indefinitely at the Finance Committee of the Board of Supervisors on May 20th.

VI. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib asked for members who wanted to attend the Patient's Rights annual reception on June 24th. Mr. Shipley and Mr. Dias will represent the Board. She noted that she and Ms. Planck had represented the Board at the Suicide Prevention annual reception.

She said that the Cultural Competency and Special Populations Committee has two co-chairs, Gloria Samayoa and Chet Villalba. She announced that the Board still has two vacancies for family members.

RESOLUTION (MHB-98-19): Be it resolved that the Mental Health Board adopts the Bylaws as revised by the Ad Hoc Committee on Bylaws, which revision is dated June 10, 1998. (Passed)

RESOLUTION (MHB-98-20): Be it resolved that the Mental Health Board cancels its meeting scheduled for August 12, 1998. (Passed)

Ms. Leib continued: We've been working on defending the Vehicle License Fee. If it is cut by the State it could be a disaster for cities and counties, including mental health services. We've sent out an R-Team Alert. And we've gotten letters to the editor published in the *San Francisco Examiner* and the *San Francisco Chronicle*.

Children's Committee

Dr. Beauford: We met to set the agenda for the 89/99 fiscal year. We'll be focusing on the quality of care and the continuity of care. We'll be looking at partnerships with other agencies, outcomes, credentialling, and after care.

CMHS Committee on a Culturally Competent System of Care

Ms. Chartrand: Tina Yee is interested in working conjointly with our MHB committee on projects to include our advocacy and consumer advocacy. Instead of having little sound bites about cultural competency we want to have a system of supporting cultural competency. We reviewed the reviews of programs looking at consumer involvement, at programs with interpreters and with people speaking other languages, at MOU's and arrangements programs have. Having consumer involvement other than clerical and janitorial is an issue we need to take seriously.

The Committee is now putting together an agenda for training for the system. We're considering training around the film "The Color of Fear." For facilitators we want Sylvia Shue from our Board and George Ketch from the California Institute for Integral Studies.

Committee on a Cultural Competency and Special Populations
No report.

Program and Services Committee
Dr. Shue: We were waiting for the proposal coming back to us to address the transportation issue. We'll get the proposal after Jane Kahan and Sidney Lam meet. We requested some information from CMHS about Attention Deficit Disorder. We put the Reinvestment proposal on the back burner. We inquired about the status of the 200 by 2,000 program.

Consumer/Family Member Task Force
Mr. Leoni: We've asked for an extension of time to work on this. We're working on our Handbook, which is our version of Bylaws. People are staying with the process.

Leadership Work Group
Ms. Leib: The meeting was all about the budget.

SFGH Community Advisory Board
Mr. Shipley: We had a report by Mark Leary. There are still 3 units at SFGH that need renovation, but that part of the budget was deleted by the Mayor. Dr. Yee and Dr. Clark are still going to be looking for alternative funding. PES needs to be renovated. Dr. Lu addressed concerns about translations. There are still 2 clients on the inpatient units who have been there over 100 days, because they cannot find long-term beds for them. Methadone slots of have increased. There are 24 people at PES, and more are expected which would take us close to calling for diversion.

Ms. Leib: What's the correlation of the census at PES and ACCESS? Ms. Ruffin: Clients at PES are emergency clients. The correlation is that as the number of emergencies go up, the demand for follow up also goes up.

Statement for the Budget Hearing
The budget is too low to meet the City's commitment to a single standard of care. One million dollars is not anything like enough money to cover the need.

V. PUBLIC COMMENT
No further comments.

VI. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:41 p.m.

DPH

SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE FULL BOARD

Wednesday, July 8, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS — 5 mins

II. REPORT OF CMHS DIRECTOR Jo Ruffin — 20 mins

III. CONSENT CALENDAR — 10 mins
A. Approval of June, 1998 Minutes
B. Approval of Requested Leaves of Absence: Lora Traveler, David Smith
See Attachment A

IV. SAMHSA GRANT SUBMISSION — 15 mins
See Attachment B

SHORT BREAK — 5 mins

V. MHB BUSINESS, MID-YEAR REVIEW: — 60 mins
A. REPORT OF CHAIR
B. DISCUSSION: Progress on goals and plans from December Retreat; Status of Board and Committees
See Attachment C

VI. PUBLIC COMMENT PERIOD — 5 mins

VII. ADJOURNMENT

SUNSHINE ORDINANCE

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SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

DPH

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UNADOPTED MINUTES

Wednesday, July 8, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Sylvia Shue, Ed.D. (Acting Chair); Tim Agar; Jim E. Beauford, Ph.D.; Millicent Bogert representing Supervisor Sue Bierman; April Martin Chartrand; Darwin Dias; Gloria Samayoa; Mickey Shipley; Chester Villalba

BOARD MEMBERS ON LEAVE: Peggy Gilleran, J.D.; Maria Leib; Toye Moses, Ph.D., M.P.H.; David P. Smith; Shawn Thomas; Lora Traveler, M.A.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

OTHERS PRESENT: Collins Munns (CMHS); Brian Peagler (San Francisco Police Department); Kent Olson (Continuum); Mike Wise (Consumer/Family Member Task Force); Mark S. Adamek (SFNHMC, SFCAB, SFDMDA); Emeric Kalman (Family Member); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Sylvia Shue, Acting Chair, at 6:35 p.m.

II. REPORT OF THE CMHS DIRECTOR

Mr. Munns reported as follows: Jo Ruffin is not here tonight due to an illness in her family. Her mother is seriously ill in Utah. Jo was already planning to take a month off during the summer, but she's had to move that up and will be gone for July. She's asked me to cover for her during this period.

There are two major areas I want to report on: 1) the budget, and 2) the Health Commission meeting.

1. The Budget

Essentially due to strong advocacy efforts there was an additional $1 million added to the mental health budget by the Board of Supervisors. We're still trying to sort out exactly what it means. The increase includes money for a hotline to be run by the Department of Human Services, and we're not sure how that will tie in. But we're glad to have extra money to sort out rather than no money at all.

However, this still leaves a shortfall with regard to funding the single system of care which we presented to the Health Commission and they adopted months ago. We're not sure that all the additional $1 million can be used for the single system of care.

2. Health Commission Meeting
We scheduled a presentation to the Health Commission, because we have a major dilemma—How does one provide a single system of care with only 40% (at best estimate) of the funding needed. We explained that that can't be done, and that we'd have to limit the criteria for receiving services, or else we'd have a shortfall of $3-4 million at the end of the fiscal year. We asked the Health Commission to review the option of phasing in the ACCESS criteria, reluctantly tightening up admissions to the system. We didn't want to do this, but we also have to meet our budget. The Health Commission had a long and intense discussion. They were extremely reluctant to modify or withdraw from the single system of care, just as we are.

The Health Commission asked us to go back to review our mental health budget to see if we could extend providing the single system of care for July and August to give us more of a baseline of data. We have 3 months now: April, May, and June. This plan would give us 5 months. At the meeting there were quite a number of eloquent speakers making the case for maintaining medical necessity criteria, for not backing away from the single system of care, and proposing that DPH and CMHS move forward on submitting a supplemental budget request.

In line with what the Health Commission is asking of us, we're going back to our budget to see if there's any way to continue the single system of care for July and August. DPH is also going back over their budget to see if they can help support this.

There was a hearing at the Board of Supervisors on Saturday June 20th. A large number of mental health advocates were present and spoke. I feel they were largely responsibly for the additional money the Supervisors put in the budget. I think the Board of Supervisors recognized the amount of support there was for mental health. We will be able to fund our existing programs, the only thing we're concerned about is the single system of care.

Mr. Shipley: I'm concerned as you go back through your budget that you don't start cutting services that are already in place.

Mr. Munns: I can say we have no intention of retrenching our services. We need an expansion instead. We'll be looking for efficiencies. We'll also be reviewing our projections. We now have additional data from our additional months of experience. We'll see if it was an initial bubble of unmet need we saw in April and May, or if requests for services continue as high as the current level.

Dr. Shue: Could you explain the single system of care for people who are not familiar with it? Mr. Munns: The State asked the counties to take over the fee-for-service system

which was run by the State. So we now have integrated the two systems. Some counties have decided to maintain tight standards on admissions. San Francisco said that mental health services should be provided in response to the need not to a formula, and we wanted to cover the indigent population. We wanted to set up a single system instead of having two tracks where the indigent population would get fewer services.

Dr. Shue: You have two months of data now. Would you say that data is consistent with the projections you made? Mr. Munns: It was consistent, but I believe we're going to see some drop off of demand in July and August as historically happens. Then it usually increases in the fall. The question is whether that will be the standard increase much like in past years, or if there will be a larger increase due to the larger number of eligible people.

Mr. Villalba: Is the $3-4 million shortfall projected based on current utilization and criteria. Mr. Munns: Yes. Mr. Villalba: But it is possible the volume could decrease? Mr. Munns: Yes. We haven't done any marketing, although the State sent out letters to everyone on MediCal in San Francisco in March, and that could stimulate requests for services. Mr. Villalba: Is San Francisco's medical necessity criteria very different than the criteria of other counties? Mr. Munns: With the possible exception of Marin, and I say possible because I don't have information about Marin, the other Bay Area counties, like San Mateo, Alameda, and Santa Clara, are using essentially the same criteria.

Mr. Wise: Are there any figures on the number of people on MediCal receiving mental health services who are also enrolled in private health plans like Kaiser, but who would not have to cut into City services if they received their services from their HMO instead? Mr. Munns: We have some figures. Kaiser was a major player at one point in providing mental health services. The State stopped paying Kaiser and Kaiser continued services for the clients they had, though they stopped taking new clients. Now since April 1st, their remaining clients have been transferring over to the City, which is as it should be. I'm not aware of large numbers of MediCal clients covered by other plans. But many other plans have mental health coverage that is not adequate for what people need.

Dr. Shue: Jim, do you know the status of Supervisor Yee's proposal regarding reinvestment. Dr. Beauford: That's been tabled. But he said he's planning to resurrect it after the budget is settled. It could be a few months to half a year. Dr. Shue: Could that help with funding? Mr. Munns: The idea of the Yee proposal is to provide more prevention services and therefore reduce the need for acute services and take the savings to fund even more prevention services. I haven't see how that would cost out, specifically the difference between cost avoidance and cost savings, and there is a difference. For example if you contract with a hospital and cut usage, you have a cost savings. But if you own the hospital and have to maintain the beds whether they are being used or not, the cost savings will be limited.

Ms. Planck: Sylvia, I think you may be thinking about the reclassification. I think that was not dependent on Supervisor Yee's proposal. Mr. Munns: That idea is to find

dollars for services provided to MediCal clients by agencies not MediCal certified. If we can link those agencies to health agencies then they can bill MediCal for the services they are providing. We're moving ahead with this plan.

Dr. Shue: Children's Services are already in 40+ schools with the Mosaic Project. Mr. Munns: There is a whole school program which is run by Children's Services apart from the Family Mosaic Project and if we can get School District providers certified then they can get reimbursed. We're moving ahead with this plan. It takes time and is very complex and involves working with the State Department of Health Services.

III. CONSENT CALENDAR

RESOLUTION (MHB-98-21): Be it resolved that the minutes of the Mental Health Board meeting of June 10, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-22): Be it resolved that the Mental Health Board grants leaves of absence for the July 8, 1998, meeting to: Peggy Gilleran, Maria Leib, Toye Moses, David Smith, Shawn Thomas, and Lora Traveler. (Passed)

IV. SAMHSA GRANT SUBMISSION

Mr. Munns: SAMHSA funding is provided by the federal government to provide mental health services. It's been a successful grant. The grant has had one problem brought to our attention by the grantors. They asked us to start moving funding from administrative positions to clinical positions. One administration position has been transferred to the City's General Fund. The other administrative positions will be replaced by ACCESS clinical positions. This will take place in the next 90 days. We have been working with the grantors very closely and they have been very cooperative as we move toward that grant funding only clinical positions.

Mr. Villalba: What month does the grant start? Mr. Munns: The federal fiscal year is different from the City's. It starts on October 1st.

Dr. Beauford: Are there certain programs under SAMHSA or is it a pool of money that can be used for anything? Mr. Munns: It's a pool of money given to cities and counties in California. In the beginning it could be used for virtually anything related to mental health, but now they are narrowing the focus.

Mr. Villalba: As the ACCESS system is implemented, what in general were the criteria for the staff? Mr. Munns: They are primarily social workers or MFCC's. They are licensed clinicians. We decided we did not want unlicensed clinicians answering ACCESS calls.

RESOLUTION (MHB-98-23): Be it resolved that the Mental Health Board certifies that it has reviewed and now endorses the 1998/99 application by Community Mental Health Services for the renewal of the grant from the Substance Abuse

and Mental Health Services Administration (SAMHSA), and will write a letter to the State of California notifying them of this endorsement. (Passed)

MHB COMMITTEE REPORTS

Community Advisory Board, Dept. of Psychiatry, San Francisco General Hospital

Mr. Shipley reported as follows: We had a report from Aline Womack who has recently be put in charge of the Substance Abuse and Addiction Department at SFGH about the expanded services for the Stonewall Project and the detox unit as well as expanded services her department is providing to the whole hospital.

Ms. Flores reported for Dr. Leary on the Department of Psychiatry. They are working on space issues. There is not enough office space for the administration. They are starting to double and triple up on office space. They are getting more administrative interns coming in. There is still no funding for the renovation of 3 units that need it, along with PES (Psychiatric Emergency Services). So it will take another year or two to do that, which is really unfortunate.

The status of long-term beds is a concern, but the issue was tabled until we can gather some more information. There are still clients on the inpatient units, because long-term beds cannot be found for them.

The clothing cart is being used daily at PES, and this gives the clients some distraction and something to look forward to. They are going to put in a hexagonal fish tank in the day room at PES in hopes that it will help calm people. They have been considering pet therapy in conjunction with the SPCA. They are working on putting together resource materials for clients.

We had a very interesting presentation on medication. It was the second in a series. Dr. Michelle Clark along with a client and a pharmacist talked about the new medications, the CMHS formulary, and the different formularies being used by HMO's.

We are considering creating a database on how much the medications cost. Some are extremely expensive, as much as $250 per month, which no consumer on SSI can afford. We are working on getting medication information in a form so consumers can understand it.

A couple sad announcements: We lost a very close friend of the CAB. Gil Lopez died of cancer last Friday.

Darwin retired last night after 4 years of service. We gave him a certificate of appreciation for all his work. We're going to miss him.

Mr. Munns: With regard to the Hospital, I notice that the Health Commission acted on a resolution to allow SFGH to accept a donation of $1.27 million—quite an achievement—for AIDS services and if not for that, then for the trauma unit.

Children's Committee
Dr. Beauford: The Committee continues to set the agenda for the next year, focusing on the inadequacy of services for children under 12 and on the continuity of care. We're looking at innovative programs, cost sharing, and partnering with other agencies.

Ms. Planck: Do you think one of the reasons services are hard to fund is because people cannot imagine mentally-ill little children? Dr. Beauford. In part it's that. But then there is the cost factor. Ms. Planck: Meaning there are not enough children to fill the beds? Dr. Beauford: There aren't enough, but there are enough—if agencies pull together. Providers are under pressure to not use the acute services, so there is under-diagnosing going on. Langley Porter, which closed its unit, had only a census of 1-2 inpatients. But their competitors have patients they couldn't or wouldn't refer to Langley Porter for different reasons. But if people pull together, it's possible to make a single inpatient program work.

Ms. Planck: I do know that the public at large is startled to find out that a 4 year old can be mentally ill. Dr. Beauford: Part of the problem is the funding that goes to Children's Services from the federal government on down. It's not enough. Dr. Shue: The culture doesn't accept it as a reality and if they don't then they won't fund it. In the Asian community, we don't have a word for depression—it's as if it doesn't exist.

Mr. Villalba: Historically the diagnosis of children's illnesses has been very illusive. I just read a study of clinicians giving Rorschach tests to kids who had perceptual difficulties. So they came up with misdiagnoses.

Program and Services Committee
Dr. Shue: We got a response from Jo to our letter about Attention Deficit Disorder. There is no policy yet, so we're returning the issue to the Committee to help work on the policy.

At the last meeting we worked on a survey we'll be sending out to the Consumer Advisory Team or CAT about the new ACCESS line and the new managed care system.

CMHS Committee on a Culturally Competent System of Care
Ms. Chartrand: What Tina Yee would like everyone to consider here is that we keep fighting for prevention programs. That's her main rallying cry for the next year. We're also looking at the training program for the next year. We're looking at doing a conference on issues concerning transgender and questioning youth.

We decided not to order the "Color of Fear" video and accompanying materials because there were too many restrictions on how it could be used and how often, and it was not cost effective. We decided to use a list from Francis Lu to order books we could use for reference materials. We also had a presentation on housing and how things have

changed dramatically in San Francisco since the 1990 census. We are working on getting more language capability in the system.

Mr. Villalba: We have a member of this Board going to the CMHS Committee, which is staff directed. Are we duplicating something with our MHB Committee? Ms. Planck: Not really. The staff are the people making the policy and implementing it. We are the watchdog agency. We don't design programs, but we look at the plans and programs developed by CMHS.

Committee on a Cultural Competency and Special Populations
A meeting was set for July 29th.

V. MHB BUSINESS, MID-YEAR REVIEW
Ms. Planck: I can tell you what Maria said to me about putting this on the agenda. It's kind of a mid-year temperature taking of the Board. How are we doing with our own goals and committees.

Dr. Beauford: I think assigning some of these goals to Committees could be good. We're already short on members for the committees.

The following decisions were made about the goals.

1. To enhance communication with CMHS, so as to establish consistency in follow-through of policies that affect mental health services and consumers; in regards to, but not limited to the following:

- *Development of standards for peer counseling performance, training and supervision.*
- *Encourage the development of education series for general medical providers, alternative medical providers and the public regarding mental health issues.*
- *Develop ways for the Mental Health Board to evaluate the consistency of mental health policies, and follow through on Board recommendations regarding these policies.*

This version of Goal #1 is the revision developed by the Program and Services Committee. The Committee will continue its ongoing work on this goal.

2. Do a review of the state of Mental Health in San Francisco

- *What is the need?*
- *Whom do we serve now?*
- *How does the Mental Health community get a city policy?*
- *How can we help city develop a policy on Mental Health (ongoing)*

Completed in the form of the Annual Report which is getting rave reviews.

3. By February form a Policy and Education Committee to educate policy makers to develop 2-year strategies that focus on individual issues as follows:

- *Develop an analysis of the expense of timely care vs. emergency*

Assigned to ad hoc Budget Committee

• *Compile a resource sheet of Mental Health services that informs people about where to get help.*

CMHS Consumer Handbook which has just been released and distributed covers this.

• *Use the Annual Report to educate*

The Report has been produced and distributed and is being used on an ongoing basis to educate city leaders and citizens about mental health needs and services.

• *This committee will ask Board member s to work on projects.*

4. *Press more for affordable housing*

• *Create a protocol or paradigm shift.*

This goes to the PR Committee or in their absence the Executive Committee.

5. *Employ media more in advocacy*

• *Press conferences on: Suicide; All need to be treated equally; To reach citizens; Educate citizens to Mental Health Board.*

Assign to PR Committee or in their absence to the Executive Committee. The section on "All to be treated equally" was assigned to Cultural Competency and Special Populations.

6. *Develop a clear policy about integrating all CMHS systems.*

This goes back to CMHS.

7. *Develop a protocol that will influence the school district on Mental Health education*

• *Preventive care*

• *Assessment*

• *Integration with medical care*

Assigned to the Children's Committee

8. *Examine amount of money spent on administration vs. programs and increase program amount.*

Assigned to the ad hoc Budget Committee

9. *Secure a liaison to facilitate the gap between Mental Health services and education*

• *Within Education Department or Department of Human Services*

Assigned to Children's Committee

10. *Explore the ramifications of the ADA on Mental Health services and consumers*

• *Increase awareness around ADA accommodations and discrimination against Mental Health consumers*

The Program and Services is working on this issue on an ongoing basis,

11. *Develop an aggressive case management model.*

This goes back to CMHS. The MHB role would be to advise and review.

The Committee on Cultural Competency and Special Populations was discussed, specifically how to make it happen that more people can attend. Mr. Agar commented: This is a new Committee. Perhaps we can give it time to evolve. There are a couple areas we've just discussed, even in the education series, to follow up on. Perhaps the Committee needs time to develop an identity. Ms. Planck: That ties in with the Committee's last agenda to develop goals.

It was decided that the next MHB Retreat would be scheduled for Saturday, December 12, 1998.

VI. PUBLIC COMMENT

Mr. Kalman: I have a few questions: 1) I want to ask if the respected members saw all the communications from the Executive Secretary.

2) I asked last month at the MHB meeting why the prevention and intervention line in the City budget was $100,000, down from $2-3 million. Why don't you have all the legislation in your packets? The Board of Supervisors just introduced 98-109 by Supervisors Ammiano and Bierman talking about youth suicide. I raised this issue last month and was never answered.

My comments were never included in the minutes, and not even my name indicating that I spoke. I raised a very serious issue. The last meeting was about the budget. I called up the secretary and said I want to see figures. This is how I found out we had 30 times less money for prevention and intervention.

Why can it not be arranged to have air conditioning for this meeting? Everyone is sleeping here.

The MHB is not spending its resources according to the State and City Administrative Code.

Ms. Planck: Mr. Kalman phoned the office today with five concerns which we typed up and which will be taken to the next Executive Committee meeting.

VII. ADJOURNMENT

There being no further business, the meeting was adjourned at 8:40 p.m.

DPH
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The Mental Health Board meeting scheduled for August 12, 1998, has been CANCELED

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The next meeting of the Mental Health Board will be Wednesday, September 9, 1998.
An agenda for that meeting will be sent out at the beginning of September.

=DPH

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MEETING OF THE FULL BOARD

Wednesday, September 9, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	**5 mins**
II. PRESENTATION: Trauma and Mental Illness Jo Ellen Brainin-Rodriguez, M.D., Unit Chief, 7-A SFGH Dept. of Psychiatry	**30 mins**
Board Member Questions	**10 mins**
III. MENTAL HEALTH DIRECTOR'S REPORT: Jo Ruffin	**20 mins**
SHORT BREAK	**5 mins**
IV. CONSENT CALENDAR See Attachment A A. Approval of July, 1998 Minutes B. Approval of Requested Leaves of Absence: Shawn Thomas C. ACTION: Transportation Solutions; from Program & Services Committee *All Consent Calendar Items to be Handled in a Single Vote*	**10 mins**
V. PROGRAM REVIEW TRAINING, TEST Please Read Attachment B.	**30 mins**
VI. PUBLIC COMMENT PERIOD	**10 mins**
VII. ADJOURNMENT	

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1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) five days before the meeting. Large print copies of the agenda will be made available upon request; please call as above, five days in advance.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in the fourth floor conference room. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. Accessible MUNI lines serving the location are the 9 San Bruno, 42 Downtown Loop and the 72 Haight/Noriega. For more information about MUNI accessible services, call (415) 923-6142.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley.

4. Individuals with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities should call our accessibility hotline at (415) 554-8925 to discuss meeting accessibility. In order to assist the City's efforts to accommodate such people, attendees at public meetings are reminded that other attendees may be sensitive to various chemical-based products. Please help the City to accommodate these individuals.

SECURITY GUARD

A security guard is stationed at the front door of 1380 Howard Street, from 6:00 p.m. through the end of the Mental Health Board meeting, to let people into the building.

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TRAUMA AND MENTAL ILLNESS

The Chicken or the Egg?

A presentation by
Jo Ellen Brainin-Rodriguez, M.D.
Unit Chief, Ward 7A
Women's & Latino Focus Unit
Department of Psychiatry
San Francisco General Hospital

At the meeting of the
Mental Health Board of San Francisco
4th Floor Conference Room
1380 Howard Street (corner of 10th St.)
Wednesday, September 9, 1998, 6:30 p.m.
Call 255-3474 for more information.

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UNADOPTED MINUTES

Wednesday, September 9, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Jim E. Beauford, Ph.D.; April Martin Chartrand; Darwin Dias; Peggy Gilleran, J.D.; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler, M.A.

BOARD MEMBERS ON LEAVE: Tim Agar; Supervisor Sue Bierman; Shawn Thomas; Chester Villalba.

BOARD MEMBERS ABSENT: David P. Smith.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

PRESENTER: Jo Ellen Brainin-Rodriguez, M.D.

OTHERS PRESENT: Collins Munns (CMHS); Michael Wise (Consumer/Family Member Task Force); Emeric Kalman (Family Member); Amelia Truman (Community Advisory Board, SFGH); Gordon Pooler (Community Advisory Board, SFGH); Terry Evans; Robert Kerby; Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:39 p.m.

II. PRESENTATION: Trauma and Mental Illness

Ms. Leib introduced Dr. Brainin-Rodriguez, Unit Chief of Ward 7A, Department of Psychiatry, San Francisco General Hospital.

Dr. Brainin-Rodriguez presented as follows: Maybe we can start with some of your thoughts and questions, then I'll do an overview on how we came to incorporate trauma into the assessment we do at San Francisco General Hospital.

Ms. Chartrand: I have a personal interest in how trauma ties in with women and domestic violence. I'm interested in studies on the trauma done to women.

Ms. Planck: I'm interested in the consequences of childhood trauma.

Ms. Gilleran: Are you discussing emotional trauma only or physical trauma as well?

Dr. Brainin-Rodriguez: In the past we've tended to focus on emotional abuse, child sexual abuse, witnessing violence, etc., but now there is more evidence that subclinical brain injuries have serious consequences. These are not severe injuries, but repeated knocks on the head cause mild deficits which make a person's life more difficult.

Ms. Traveler: I'm interested in trauma experienced by teens, ages 13-18.

Dr. Beauford: What treatments have been most successful on the ward? What kind of staff do you need? What kind of training do they need to be effective?

Ms. Traveler: I'd like to know about the traumatic effect of involuntary holds.

Dr. Brainin-Rodriguez then provided an overview as follows: I've been at San Francisco General Hospital for ten years. I received my training at McAuley Institute of St. Mary's Hospital. I was fortunate to be trained where people were interested in the sequelae of trauma. I was interested in such issues as multiple personalities, multiple dissociative disorder, repressed memories, and the actual mechanisms of how we understand repression and memory. It's not been universal that these issues are addressed in psychiatric units.

During a time of crisis is not the time to be asking people questions about their history of trauma. The fear is that you will overwhelm people by asking those kinds of questions.

The women's unit was set up to address the needs of pregnant psychiatric patients, issues of medication, and Cesarean section, but as we began to work in these areas, we became clear that we were missing a lot of issues. We begin asking women (and all patients) what their experiences were growing up, including abuse and witnessing abuse, ending up on the street, exchanging sex for food, being assaulted by predators out on the street. Just being out on the street places you at risk for trauma. The same is true with substance abuse. You find yourself in weird and dangerous places at night with individuals who are not trustworthy, where guns are often present. Studies show that people with mental illness are at higher risk to have had traumatic experiences in their life, but that's often not taken into account.

But how does that affect your ability to establish a relationship of trust with your case manager or others responsible for your care? In reviewing patient charts, you see that Post Traumatic Stress Syndrome is rarely ever included in the diagnosis.

Part of the problem is that providers are not asking the questions we need to ask to get the information. The presentation of trauma in mental illness may not be the classic presentation. People with borderline personality disorder occupy 25% of psychiatric

beds. There is a lot of evidence to show that these people have lots of trauma in their background. Lists of the characteristics of people with borderline personality and people with PTSD are similar, but in the case of people with borderline personalities, the traumatic events in their lives have not been identified—such as sexual assault, physical assault, abandonment and neglect that went on for long periods of time.

When trauma occurs for long periods of time, and over different developmental stages, it changes the personality. When people have had a lot of trauma in their lives, their coping mechanisms get overwhelmed.

As we began to look at these issues we realized that we weren't screening everyone who walks in the door to see if they had a history of trauma. We're better at getting this information on little kids because we rely more on collateral information. With adults, if the person skips most of the trauma questions, no one asks the siblings, for instance, for that information.

We created a trauma screening tool so intake staff can know what to ask so we can begin to get a mot more histories of trauma and a lot more details.

The Latina Focus was started 13-15 years ago. It was started in order to meet the needs of Spanish speaking patients and the immigrant population. Many of the immigrants had been through traumatic border crossings, or had left situations of war, insurgency, and civil unrest that were very traumatic.

More and more we are getting women referred to us because they have trauma. Before it was issues of pregnancy and child bearing. Now trauma has become the focus of the team. We began to see a big influx of women with trauma with self-injurious behavior. We use the theoretical background of Marsha Linehan. She has done research on self-injurious behavior.

At the time, Ann Jennings worked at the CAB. She was very interested in trauma due to the experiences of her daughter. Since then it finally occurred to all of us that this is a problem we cannot solve on one unit at SFGH, because we're talking about 80% of clients having histories of trauma. Lots of the male patients have trauma, too. The sexual abuse rates are higher for women, but still for males the rates are fairly high. We realized we're dealing with a really big problem that concerns everyone. We need to integrate information about trauma into training for the residents. We need to integrate questions about trauma into the database forms which are used at admission. We need to have cues to alert people to ask about trauma.

With regard to head trauma, we under-ask. When you ask, "Have you ever had a head injury that led to loss of consciousness?" that's a high standard. Smaller knocks to the head can cause damage and the effect can be cumulative. I got interested in this interviewing a woman with short hair. I could see scars on her scalp, lots of them. I looked at the chart. There was a long history of visits to the emergency room. There was

no loss of consciousness, but there were lots of stitches. She was sort of a bland person, with lack of content in her speaking. Trauma could be part of the explanation for that. The injuries were called subclinical, but they could still cause problems.

Ms. Samayoa asked about the cause of the injuries. Dr. Brainin-Rodriguez: She was a young woman who was out on the streets in the sex trade and was abusing drugs and had an abusive boyfriend.

PTSD hardly ever walks by itself. Most people who come in with PTSD, by the time we see them, have had multiple traumas over the years and have adapted to the PTSD's. The group of people functioning the worst and having the most trouble out there in the community, almost always have more than one diagnosis.

We try to be as inclusive as possible, even though there is only one line for the diagnosis on the form. Including all diagnoses shows the complexity of the issues the person is dealing with. We make things more understandable, although we don't make things simpler by including all the diagnoses. This also makes it harder to refer our clients to outpatient services since so many of them have dual diagnoses and there are not many beds for them.

This comes as no news to the front line providers in the community that the vast majority of substance abusers have histories of trauma and have mental health issues, and vice versa with mental health providers.

We make tons of referrals to Substance Abuse Services. We work alot with SAGE, an organization that works with women in the sex trades. It can help a client to see other women who are far along in their treatment who are doing well. It's important to remember that these clients also have lots of strengths to work with.

With regard to the subtitle of my presentation, "The Chicken or the Egg?", all things are related to trauma. If you work through your history of trauma, everything else will get better. There are people who are traumatized and then are in distress. There are people with underlying mental illness and then trauma occurs on top of this. For example, if a person has a diagnosis of chronic paranoid schizophrenia, and then they have a traumatic event occur in their lives, they may not be able to process that event well. They may continue to carry it. We may not be able to solve the problem just by understanding the trauma.

But understanding the trauma humanizes the patient to the staff and the resulting therapeutic alliance can make a difference. There are clients who are so difficult for staff to work with, clients who are angry and help-resistant. For staff to understand their history of trauma may make working with that client much more bearable, and may open up possibilities.

Not long ago we had a woman with a diagnosis of schizophrenia. She had disclosed a history of incest to her mother. When we talked with her about that, she was as clear as anyone. She really didn't have underlying psychiatric issues. She was psychotic in the moment, but due to the disclosure issues about her incest history.

On our unit we have a range of groups: risk reduction group, sex education, women's group, men's group, and community meetings.

Ms. Traveler: I'm concerned about trauma that might occur in the teen years or at puberty. We see more and more at risk children in the public schools, more and more children being abused.

Dr. Brainin-Rodriguez: At SFGH we see adults primarily, so I'm not an expert on kids, but for a lot of our adult clients, the problems started during adolescence. Supervision drops off then, and many mental illnesses emerge at that time.

There is a tremendous amount of sexual harassment that happens in schools and it's traumatic. The kids with histories of abuse are more at risk due to their lower self-esteem. They may have impulse control and anger management problems.

I'm involved in training medical students. Since I'm kind of a fanatic about trauma, I try to incorporate it into everything. It's basic. There are lots of reasons why people don't ask about trauma. If you ask providers if it's important to ask patients about their history of trauma, the providers will say yes. But they don't do it. Just like we don't ask about sex and death, because it's hard. These questions bring up our own feelings. Also you uncover stuff that means a much longer assessment and more complicated treatment. We need to have something for providers to do next with trauma information and with disclosures.

We're working on making the outpatient agencies aware of trauma and its consequences and getting services on board with understanding that trauma is part and parcel of what we do.

Mr. Wise: It would it be hard getting trust on your side when people have had bad experiences regarding trust in other treatment settings.

Ms. Gilleran: I believe that focusing on training is important. You pointed out that large numbers of people with trauma look like people with borderline personality disorders, and people with borderline personality disorders are notoriously unpopular. Perhaps if during training some of the origins of rage and rambling problems and uncomfortable problems were explained, there would be more understanding and providers could focus on the cause and not just an amorphous difficult person.

Dr. Brainin-Rodriguez: Just having information about histories of trauma in the database can help providers understand as the patient goes from one treatment setting to another.

The greatest complaints of trauma within the system center around PES—when people are most vulnerable. The complaints are either about the police or PES staff.

If you staff a unit with people who don't speak any language but English, then people who don't speak English will not feel they are getting good services. If a person comes in having been traumatized and someone can't even inquire, then when you come upstairs to the inpatient units, you won't want to trust the staff.

Knowledge is power. If you know a person has had trauma, or if you assume they have a history of trauma, then you can help talk them down even as you have to put them in restraints. You can give them a choice of being restrained on their stomach or on their back. And you want get them out of restraints and out of seclusion as quickly as possible.

III. REPORT OF THE CMHS DIRECTOR

Mr. Munns reported for Jo Ruffin. He distributed a handout with a memo on the single standard of care from Mitchell Katz, Director of Public Health, and with an analysis from CMHS of the past four months of experience with the single standard of care.

Mr. Munns: You may recall that approximately two and a half months ago the Department went to the Health Commission after two months experience with the new health system. We reported that if we continued the single standard of care, we would have a deficit. The Health Commission asked the Department to go back and review the date and refine the numbers with more months of experience. On September 15th we'll return to the Health Commission with four months of data, and with data from the experiences of other counties.

The information reveals that there will be a deficit of $2-3 million. We will have to have additional money or we will run out of resources by December or January.

The Resolution that is going before the Health Commission includes the following paragraphs:

> RESOLVED, that the Health Commission reaffirms its commitment to a policy of providing a single standard of access to care for indigent and uninsured residents and Medi-Cal beneficiaries; and be it further
>
> RESOLVED, that the Health Commission supports a phase-in of the Mental Health Plan's ability to provide a single standard of access to care consistent with the availability of funds to cover expenses; and be it further

RESOLVED, that the Health Commission directs the Department of Public Health to use the available funds in fiscal year 1998-99 to provide equal access to care for General Assistance recipients, homeless people and children up to 200% of the federal poverty level; and be it further

RESOLVED, that the Health Commission recommends that the Department of Public Health develop a budget for fiscal year 1999-2000 that expands equal access to care to all uninsured persons in San Francisco.

What this means essentially is that the Department will recommend to the Health Commission that we restrict the single standard of care to certain people and then phase in the single standard in 1999-2000.

This is a difficult recommendation for the Health Commission to make. They have made it clear they would rather not restrict the single standard of care, and it is difficult for them to modify their policy.

Dr. Beauford: What new information do you have to include in the cost projection that's going to address the shortfall?

Mr. Munns: The Health Commission asked us to look at cost efficiencies to see if there were savings that could be made. The magnitude of the efficiencies is in the range of hundreds of thousands, which we should pursue aggressively, but the shortfall is in the millions.

At the earlier meeting, the Health Commission was concerned that we might be rushing to judgment. They hoped that there might be a reversal in the trend toward increasing demand for service which was seen in the first two months. But no reversal occurred.

Ms. Traveler asked about the authorization of claims.

Mr. Munns: If you have a client coming into the system, we might authorize 10 visits—a package of services. The client might only use 8 visits and the problem will be resolved. So that shows up as an over authorization and makes it difficult to predict. What causes a shortfall is having too many people in your system as compared with the resources available—especially in the private provider network.

IV. CONSENT CALENDAR

RESOLUTION (MHB-98-24): Be it resolved that the minutes of the Mental Health Board meeting of July 8, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-25): Be it resolved that the Mental Health Board grants leaves of absence for the September 9, 1998, meeting to: Tim Agar, Shawn Thomas, and Chet Villalba. (Passed)

RESOLUTION (MHB-98-26): **Be it resolved that the Mental Health Board write a letter to Jo Ruffin expressing support for the Mobile Crisis Treatment Team/Caduceus Outreach Services proposal for a Consumer Peer Counselor to provide follow-up services, including transportation, to fragile clients; and for the STEP Program's need for resources to increase its transportation services to clients in Residential Care. (Passed)**

V. PROGRAM REVIEW TRAINING

Ms. Leib commented that program reviews are one of the most important things Board members do.

Dr. Shue and Ms Planck reviewed the training packet and test. They also reviewed some of the procedural information about reviews.

Some of the key points that were made included:

Let the clients know that you are not in anyway connected with the staff or program. Let them know you are a volunteer from the community.

Let them know that this is an anonymous interview and that it's voluntary, that it's not part of their treatment. Don't write down their name anywhere.

Make sure the Client Notice and the Invitation Letter are both posted in the treatment center.

You can invite clients to talk with you even if they aren't signed up in advance.

Write up your report as soon as you can after the review.

Rate the specific areas first, then do the final overall rating.

VI. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib: There's an additional opening for another MHB representative on the Quality Policy Committee. On August 27th, the MHB's "Consumer-Friendly Business Awards" were presented to Rose's Deli and Walgreen's, both on Potrero Avenue. Supervisor Amos Brown was present and made very complimentary remarks about the Mental Health Board. The Board of Supervisors and the Health Commission presented certificates to accompany the MHB Award.

Children's Committee

Dr. Beauford: No meeting was held last month. The Committee will resume meeting this month.

Program and Services Committee

Dr. Shue: Nothing to add to the Program Review Training.

Committee on a Cultural Competency and Special Populations
The Committee announced that it will take on a new population: the transgendered community. The next meeting will be open to the whole Board and will be a presentation by representatives of the Transgendered Information and Independent Living Center.

Ms. Leib passed around the Bed Committee Consumer Guide with program descriptions and photos of residences, and commented that Tina Yee and Nancy Presson had developed the guide. She said it was very well done and very helpful to consumers, providers, and family members.

Mr. Shipley announced that he would be attending the meeting of the California Association of Local Mental Health Boards next weekend in Oakland.

VII. PUBLIC COMMENT
A member of the audience made the following comments: I was forcibly ejected from the Family Services place today. The doctor became very irritated because I asked for my records. He said I could go out and become a serial killer. I went back today because I was almost out of my medications and that's when he threw me out.

I was accused of assaulting a woman at the Center on Market Street. I talked with Tom Mesa and never heard back from him. I filed a grievance with Mesa and he simply asked the Market Street place for a report from a doctor there, and that's all.

Mr. Munns agreed to talk with the speaker following the meeting.

Mr. Kalman: I raised a series of issues at a previous meeting and would like to ask you if there has been any action. Ms. Leib: In response to your issue about the minutes, members of the public are not allowed to edit the MHB minutes. Ms. Planck: We talked about your issues at the Executive Committee meeting. Not every comment made during an MHB meeting goes into the minutes.

Mr. Kalman: I should have been invited to that meeting. There was a budget hearing at the Board of Supervisors on June 20th. At the end of the hearing, Supervisor Teng said that the Board could make no changes because of the need to have a balanced budget. We should have been told that before the hearing, so we wouldn't have wasted a Saturday.

Ms. Gilleran: Ordinarily we would not specifically ask a person to come to the Executive Committee meeting when we're discussing a procedural issue rather than a personal issue, such as the policy for including things in the minutes. It's procedurally set up that only Board members approve or disapprove the minutes.

Mr. Kalman: The way I see it, if someone raises serious issues they should not be excluded. Mr. Shipley: Under the Sunshine Ordinance all of our meetings are open to the public. Ms. Leib: If you have a burning issue, you can take it to one of the Committees. That's where the work gets done.

VIII. ADJOURNMENT

There being no further business, the meeting was adjourned at 9:02 p.m.

DPH

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MEETING OF THE FULL BOARD

Wednesday, October 14, 1998
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

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AGENDA:

I. CALL TO ORDER, INTRODUCTIONS — 5 mins

II. SPECIAL PRESENTATION: Follow-up on Case Management Study — 45 mins
Bob Okin, M.D., Chief of Psychiatry, SFGH
Kathy O'Brien, MSW, Clinical Supervisor, Case Management Program
Board Member Questions — 20 mins

SHORT BREAK — 5 mins

III. CONSENT CALENDAR See Attachment A — 10 mins
A. Approval of September Minutes
B. Approval of Requested Leaves of Absence: April Chartrand
C. Information Letter on CAT Survey
All Consent Calendar Items to be Handled in a Single Vote

IV. MHB COMMITTEE REPORTS, OTHER COMMITTEES — 25 mins
- Executive Committee, Chair's Report
- Children's Committee
- Cultural Competence/Special Populations
- Program and Services: ACTION See Attachment B
- Consumer/Family Member Task Force
- SFGH CAB
- CMHS Committees, MHB Representative Reports

V. PUBLIC COMMENT PERIOD — 10 mins

VI. ADJOURNMENT

Collins Munns, Director of Systems of Care, will be present for Director Jo Ruffin, who will be at a conference. Due to the expected length of our scheduled presentation, there will be no verbal report from CMHS. Board members with questions for CMHS Administration may direct them to Mr. Munns.

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UNADOPTED MINUTES
Wednesday, October 14, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Tim Agar; Millicent Bogert for Supervisor Sue Bierman; Toye Moses, Ph.D., M.P.H.; Brian Peagler; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.; Lora Traveler, M.A.

BOARD MEMBERS ON LEAVE: Jim E. Beauford, Ph.D.; April Martin Chartrand; Peggy Gilleran, J.D.; Shawn Thomas; Chester Villalba.

BOARD MEMBERS ABSENT: Darwin Dias; David P. Smith.

ADJUNCT BOARD MEMBERS PRESENT: Steve Leoni.

PRESENTER: Robert Okin, M.D., Chief of Psychiatry, San Francisco General Hospital
Kathy O'Brien, L.C.S.W., Program Coordinator, Emergency Department Case Management Program, San Francisco General Hospital

OTHERS PRESENT: Collins Munns (CMHS); Nancy Presson (CMHS); Anita Burton (Advocate); Andra Beninate; Michael Wise (Consumer/Family Member Task Force); Amelia Truman (Community Advisory Board, SFGH); Gordon Pooler (Community Advisory Board, SFGH); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:37 p.m. Brian Peagler, a new member of the Mental Health Board, was introduced. He was appointed by the full Board of Supervisors to a Family Member Seat. Mr. Peagler is a police officer and works for the San Francisco Police Department.

II. PRESENTATION: Follow-up on Case Management Study

Ms. Leib introduced Ms. O'Brien who began the presentation. Dr. Okin joined her part way through the presentation.

Ms. O'Brien made the following remarks: The Emergency Department Case Management Program was initiated by the Department of Psychiatry with the Emergency Department in response to the frequent users of medical emergency

services. We identified who they were, to see if we could reduce their use of medical services and link them to programs which could meet their needs.

First a chart review was done in 1992-93 to identify people with 12 or more visits to the Emergency Room in a one-year period. During that period 40,000 plus people had been seen in the Emergency Department with an average of 1.4 visits per person. We found 202 people with 12 or more visits. This was a tiny percentage of all the people seen (0.49%) in the Emergency Department. Of this 202, 85% were male, 82% were homeless, 59% were African American, 31% were Caucasian, 7% were Latino, and 3% were Native American.

Most of them were homeless, indigent, and had a complex array of medical problems. They had a high rate of substance abuse. We were interested in seeing if assertive case management could meet their needs. They had high rates of depression and anxiety, and undiagnosed post traumatic stress disorder. Many had chronic medical conditions. There were large rates of seizure disorders and head trauma. They came in repeatedly with injuries from life on the street.

We wanted to see what difference assertive case management could make. Margarie Davis, L.P.T., began doing this work. She went down to the Emergency Department and encouraged patients to work with her. She engaged 24 patients and 16 stuck with her. We lowered the threshold for eligibility to 5 visits in the Emergency Room in 12 months. This is a voluntary program.

Fifteen of the sixteen showed significant reduction of inpatient visits, including the number of admissions and length of stay. We also saw a reduction of homelessness and substance abuse. Thirty-eight percent reported some significant period of clean and sober time.

The Department decided to continue the program. In July of 1995, three full time social workers were hired, and I was hired along with them.

The population we work with is a reluctant population. We start by working on small, concrete needs, such as getting them bus tokens. We ask them to tell us their story. The staff have assessment skills. One example of a case is an older man who was living in an SRO hotel in the Mission District. He didn't mind a visit but he did not want case management. But 3-4 months later his hotel burned down. Then he called me for help. This was typical of the engage/back away/re-engage pattern we see.

Between July of 1995 and August of 1996, we opened 92 cases. Forty-five of the clients were opened for at least 3 months.

There was a 30% reduction in inpatient admission and a significant reduction in length of stay. There was a 77% increase in outpatient medical visits. There was a reduction in homelessness. There was a self-reported reduction of substance abuse.

This is very much a hands-on, community-based program. We do not wait for clients to come to us but instead reach out to them. For some the Hospital is like a second home. Others don't want to be around the Hospital and you have to meet them under the 280 freeway or know their street names and find them on street corners.

With regard to the medical appointments, we make the appointment and then go with them to the appointment. We prepare them ahead of time about the questions they have for the doctor. We make sure the recommendations made by the primary care providers are appropriate to the patient's life. Providers are so rushed they sometimes don't think about the realities of the patient's lives. (For example, a homeless patient cannot keep their medication refrigerated.)

We deal with the immediate short-term goals people are invested in working on and then weave in help on larger psychological issues.

We have to do intensive networking with complex systems of care and keep removing barriers so people can get their needs met.

Beginning in 1997, we hired four more staff, so we have a total of 8 full-time case managers now. A few months ago we hired a nurse practitioner to add medical expertise to the team and we're hoping to share a primary care provider as well.

The Department of Public Health is interested in a rigorous evaluation of the Program. We are doing a randomized research study. Now instead of wooing clients, we invite them to participate in the research. Two-thirds are randomized to case management, and one-third to usual care. If they can understand and consent to that, at that point we find out if they are assigned to case management.

Our philosophy is that we are client centered. We provide the least restrictive treatment. We are tapping into the client's strengths.

We have come to understand the heterogeneity of the homeless population. There is a tendency to lump them all together, but there is a great diversity. What prompts homelessness may be substance abuse, mental illness, or economic problems. Some of the homeless have lived a for a fairly lengthy period in poverty and then slide into homelessness. They often have survival skills. For others, homelessness is fairly new and they have internal adjustments to make in terms of rage and shame.

We follow a harm-reduction philosophy. We don't expect our clients to be clean and sober—or we'd have almost no one. We evaluate each time we see them whether they can do work now or not. If not, we invite them to come back later. We pay attention to safety issues. A lot of our clients have learned to lead with intimidation and manipulation. We make no-harm agreements with them. We build a sense of respect and trust.

We practice solution-focused work. We stay in the solutions and let them be the guide instead of getting into pathology. Some of the women have such a history of abuse and bad choices of partners that they want to put all the responsibility on the case manager to fix things. But we let them know that we're teaming on this, and that can be anxiety producing.

What we do is just slow, hard work. I'm amazed by the staff and how they support each other and keep their sense of humor. The clients come in with precious little, expecting precious little. The work is two steps forward and one step back. Each little thing takes repeating and repeating.

Dr. Okin arrive at this point and made the following remarks: When I came last time to the MHB meeting, I talked about the preliminary results of 16 patients, and the results were positive. The question was: Was this a fluke or would it hold up?

When we talk with case managers we hear wonderful success stories. And when you know the challenges of the clients, it's all that much more of a success. I want to express my appreciation to Kathy who manages the program. She's a wonderful colleague and it's a very complicated program to run, because of the complexity of how the medical and psychiatric issues play off each other. There's nothing else like this Program anywhere else in the country to follow.

What I'm going to show you is still considered preliminary. We are comparing the year prior to the program to the year following the program. This is a pre-test/post-test comparison. The problem with this comparison is that we don't know what would have happened without the program. Many of these clients are seriously ill. If they had not been in the program their illnesses might have gotten worse, or the illnesses might have resolved themselves. Maybe if we had done nothing, the clients would have done well anyway.

We can't tell if the results are really a product of the program. But there are certain changes we've seen in many of our clients that are hard to imagine happening without our intervention.

Because the results are exciting, I want to be modest about the meaning of the numbers. We're now doing randomized studies. We can't serve everyone, so an ethical way to decide who gets service is randomized assignment to the program. This is the gold standard in research.

We try to get as many people as possible who don't have entitlements on entitlements. SSI and MediCal are set up to discourage people from getting on them. We try to hold our clients while they are going through the process—standing in line, filling out forms, going through appeals. We show a 52% increase in clients getting entitlements, including food stamps. The SSI process is so complicated, I can't even keep up with it.

We've fairly successfully reduced the extent of homelessness in our clients. Without that it's hard to accomplish anything else. The decrease in homelessness is 57%. The decrease in substance abuse is 22%, based on self-report. Most are reporting reduction of use. A smaller percent is reporting a commitment to program and are having periods of being sober.

For the research study, the case manager fills out a check list every month, both for the clients in usual care and in case management. So this is a double check on the client's self report.

In one case, Margarie helped the client to decide to only drink in his hotel room, not in the lobby. This was in part so he wouldn't get kicked out of the hotel. Then he reduced his level of drinking. The case manager and the hotel staff could all see the difference.

Drug use decreased by 22%. You might say this is not a huge change, but given the depth of use of drugs and alcohol, I was impressed. I wasn't sure we were going to get any change at all.

The outpatient visits to primary care providers and specialty care increased by 82%. But people needed this care, so this is a success.

Overall, medical emergency visits decreased. For 72% of clients, the visits decreased. For 28% the visits increased. We have not analyzed this yet. It may be the some of the 28% had chronic medical conditions, and became sicker and sicker as time went on and they neared the end of their lives. Or perhaps there was something we could have done to decrease their number of visits.

There are three broad populations coming into the Emergency Department:

1. People found down on the street who are brought in by ambulance in pretty bad shape.
2. People with ongoing medical conditions.
3. People who are relying on the Emergency Room for non-urgent medical care or for meeting psycho-social needs, such as getting a shower.

The total number of Emergency Department visits were 947, which was a decrease of 27%. An Emergency Department visit doesn't cost that much. What's more tied to cost is inpatient medical treatment. It's a better indication of improving health. Inpatient admission for medical services decreased by 28%.

The total cost of hospital services, including the cost of the Program, decreased by 23% from $1,832,082 to $1,402,618. This seems to represent a real offset of costs, but extracting savings is not really possible, because the infrastructure remains the same. We'd need to be able to close down a ward and reduce staffing to get a more dramatic cost reduction.

Because this society really has been so hard on people who are disabled in a psychosocial way, the only way they've been able to get care is through medical care and medical programs don't do so well in giving them the kind of care they need. But if we included the cost of alcohol programs and subsidized housing, then the cost would be higher, and we'd want it to be higher. Then we would have moved the cost from the medical services to the psychosocial services. But if you include the reduction of the cost of jail, police, and judges that would skew things back in the other direction.

With our first 16 clients the arrest rate went down 33%. That's a small sample and I don't know what it really means. The average heroin user spends $400 per day on heroin. You know they are not getting that money from their grandmothers. Someone's paying the price for that through stolen car stereos and other kinds of crime.

Ms. Traveler: That's true for people who are poor. Wealthy people who are paying even more than that are not reported.

Dr. Okin: Whatever the randomized study shows, I will tell you the case managers have had a profound impact on certain people's lives.

Mr. Peagler: Is the Program restricted to San Francisco residents only? Ms. O'Brien: Yes, but if the person is homeless then there is no residency requirement. If the person has MediCal from a different county, then we have to look at that and follow up.

Mr. Shipley: Is there any kind of speculation why the majority of the clients are African American males? Dr. Okin: I think it really has to do with the nature of racism and discrimination in this country and the history of slavery which is still with us. African Americans have continued to be treated as disposable.

Ms. Traveler: Do any of the women in the Program have kids and if so what happened? Ms. O'Brien: Others are taking care of the children, family members or foster care. Some of the clients re-establish contact with their kids in a good way. We work with families when they are willing to stay involved.

Ms. Leib: Are there more African American women than other ethnicities? Ms. O'Brien: Yes, that stays the same.

Dr. Shue: Will you incorporate language as well as ethnicity? Dr. Okin: Yes. Ms. O'Brien: We have two bi-cultural, bi-lingual Spanish speaking staff, and one bi-cultural, bi-lingual Vietnamese staff. Ms. Traveler: How many case managers are African American. Ms. O'Brien: Two.

Mr. Wise: Does the rise in outpatient services raise costs? Dr. Okin: The cost of an inpatient day is so expensive it takes a whole lot of outpatient visits to equal that cost.

Mr. Leoni: I really commend what I heard about the style of engagement of case management. What do you know about which parts of what you do are necessary and unnecessary. Dr. Okin: That's a sophisticated question. We don't want to do anything more than necessary, but nothing less than necessary. To be able to answer that question we'd need to do a disaggregation study. We'd have to take out pieces of the program one by one and see what the results were. But that kind of study can only be done after a randomized study gives you a baseline.

Ms. Lieb: What impact does this Program have on Community Focus, the single point of responsibility program at SFGH? Dr. Okin: I have never tried to sell good programs on the basis that they will save the Department money. I think there will be a decrease of cost over time, but it takes time. The single point of responsibility programs have decreased the hospitalization rates of clients by 60%. This is wonderful just in human terms. I think there needs to be a study of the single point of responsibility program like what we're doing.

III. CONSENT CALENDAR

RESOLUTION (MHB-98-27): Be it resolved that the minutes of the Mental Health Board meeting of September 9, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-28): Be it resolved that the Mental Health Board grant leaves of absence for the October 14, 1998, meeting to: Jim Beauford, April Martin Chartrand, Peggy Gilleran, Shawn Thomas, and Chet Villalba. (Passed)

RESOLUTION (MHB-98-29): Be it resolved that the Mental Health Board write a letter to Jo Ruffin informing her of the results of the July 22, 1998, Consumer Advisory Team survey regarding the new mental health system, and also giving her comments from members of the Board about the new CMHS Client Handbook. (Passed)

IV. MHB COMMITTEE REPORTS

Executive Committee

Ms. Leib: I've been making the rounds to the Health Commission and DPH and one Supervisor concerning the single standard of care. On October 20th the Health Commission will be discussing it again. Supervisor Sue Bierman will be holding a hearing on October 22nd to support a supplemental appropriation to make the single standard of care possible. I think there is quite a bit of support for a supplemental appropriation and it's important for us to keep working for it.

On Wednesday, October 28th, April Martin Chartrand of our Board will be receiving the Isabel Cerna Award from the Commission on the Status of Women for her work on domestic violence issues.

On Thursday, October 29th, our Executive Director, Mary Sue Planck, will be receiving the Honorary Consumer Award at the Second Annual San Francisco Consumer Awards reception.

Children's Committee
Ms. Samayoa: We worked on the goals of the Committee, focusing on the relationship of CMHS and the School District, including Special Education, and the issue of access to those services.

Committee on a Cultural Competency and Special Populations
Ms. Samayoa: We had a great meeting. We had a panel from the Transgender Independent Living Center. They told us stories of their lives and talked about receiving mental health services. They talked about the mistreatment they experienced at shelters in particular.

Mr. Agar: I, too, thought the presentation was outstanding. From an advocacy perspective I want to do a site visit at the Tom Waddell Clinic and follow up on this.

Program and Services Committee
Dr. Shue: We spent the better part of the meeting working on program reviews. We also worked on a letter to Jo Ruffin recommending that providers make sure that when people are given things to sign they are in a state of mind to give consent, that they can really understand what they are signing.

Ms. Planck: When we were looking through old program reviews we saw reports of people signing things which they didn't understand. The letter recommends that things like patient rights and medications be explained more often than just at intake.

> **RESOLUTION (MHB-98-30): Be it resolved that the Mental Health Board write a letter to Jo Ruffin recommending that CMHS make it an official policy that required information be given to clients as often as necessary to be sure that they understand it and that "informed consent" is truly informed. (Passed)**

Consumer/Family Member Task Force
The Task Force has been requested to take the Handbook back to the full membership for changes. When the changes are made there will be a 9-month trial period. We are attempting to turn the culture of the Task Force around. Most of the objections from the MHB Executive Committee to things in the Handbook were not to things we've recently added but to things that have been in the Handbook since 1995.

Community Advisory Board, Department of Psychiatry, San Francisco General Hospital
Mr. Shipley: The Hospital has been providing more trainings in dual diagnosis and harm reduction.

There is a major project going on to reduce seclusion and restraints on Ward 7B. That ward has gone from the highest amount of seclusion and restraints to the lowest. The assault rate is also way down. This change is attributed to increasing the food budget to provide snacks during the day. It turns out the patients were not getting enough food. The kitchen is left open now so patients can get something to eat for themselves whenever they want it. Amelia and others also come through the ward with a clothing cart. And the ward has been remodeled. It's now carpeted and is more comfortable and quieter. And they've put in exercise equipment.

The unfortunate thing is that it cost the Hospital $160,000 to do the remodeling and additional $20,000 for the increased food expenses. It would cost at least another $600,000 to upgrade the 2 other units that need it. We'd like to have the MHB join the CAB in advocating with DPH for the additional funds.

CMHS Quality Policy Committee
Mr. Shipley: We're opening up the process of policy and procedure for more discussion. We had a report on how the revamped Grievance Procedure is going. We're getting ready for an audit of the system in November.

V. PUBLIC COMMENT
Mr. Leoni: My understanding is that in November the State is doing a major oversight review—like a program review of the County by the State. Consumers and family members from other counties will be here to interview focus groups of people from San Francisco. How will CMHS be selecting the members of these focus groups?

Mr. Munns: I don't know at this point, but I'll find out the answer to that.

VI. ADJOURNMENT
There being no further business, the meeting was adjourned at 8:45 p.m.

DPH

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MEETING OF THE FULL BOARD

Tuesday, November 10, 1998 *
1380 Howard Street, 4th Floor Conference Room
6:30 p.m.

AGENDA:

I. CALL TO ORDER, INTRODUCTIONS	**5 mins**
II. SPECIAL PRESENTATION: Quality Management An Overview of CMHS Quality Management Plan Bill McConnell, Ph.D., Director, Quality Management	**45 mins**
SHORT BREAK	**5 mins**
III. CONSENT CALENDAR See Attachment A A. Approval of October Minutes B. Approval of Requested Leaves of Absence C. Adjunct Team: Shawn Thomas is applying ***All Consent Calendar Items to be Handled in a Single Vote***	**10 mins**
IV. DIRECTOR'S REPORT: Jo Ruffin, CMHS Director	**20 mins**
V. MHB COMMITTEE REPORTS, OTHER COMMITTEES •Executive Committee, Chair's Report •Children's Committee •Cultural Competence/Special Populations •Program and Services •Consumer/Family Member Task Force •SFGH CAB •CMHS Committees, MHB Representative Reports	**25 mins**
VI. PUBLIC COMMENT PERIOD	**10 mins**
VII. ADJOURNMENT	

*** Please note change in meeting date. The usual date (Second Wednesday) is a holiday, so for this month only the meeting will be on the second Tuesday.**

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UNADOPTED MINUTES

Tuesday, November 10, 1998, 6:30 p.m.
1380 Howard, 4th Floor Conference Room

BOARD MEMBERS PRESENT: Maria Leib (Chair); Tim Agar; April Martin Chartrand; Renee Deger; Darwin Dias; Toye Moses, Ph.D., M.P.H.; Gloria Samayoa; Mickey Shipley; Sylvia Shue, Ed.D.

BOARD MEMBERS ON LEAVE: Jim E. Beauford, Ph.D.; Supervisor Sue Bierman; Peggy Gilleran, J.D.; Chester Villalba.

BOARD MEMBERS ABSENT: Brian Peagler; David P. Smith; Lora Traveler, M.A.

ADJUNCT BOARD MEMBERS PRESENT: None.

OTHERS PRESENT: William McConnell (CMHS); Carlos Balladares (CMHS); Mark Adamek (San Francisco Network of Mental Health Clients, San Francisco Depressive and Manic Depressive Association); Mary Sue Planck (MHB); Rich Snowdon (MHB).

I. CALL TO ORDER/INTRODUCTIONS

The meeting was called to order by Maria Leib, Chair, at 6:40 p.m. Renee Deger, a new member of the Mental Health Board, was introduced. She was appointed by the full Board of Supervisors to a Family Member Seat.

II. SPECIAL PRESENTATION: Quality Management

Dr. McConnell: Let me first introduce Carlos Balladares who is in charge of Provider Support and Compliance, which mainly means Program Reviews.

Tonight I'll be presenting, not an overview of the Quality Management Section of CMHS, but an overview of the Quality Management Plan for the whole system. I'll go over the goals, how the Quality Management System is structured, who participates and how.

Dr. McConnell then projected computer slides on the screen and covered the following points:

QUALITY MANAGEMENT SYSTEM OVERVIEW
Quality management system goals
Quality management system structure
Input and participation in the quality management system
Quality management indicators
Quality management committees

GOALS
To deliver the highest quality of care possible
To identify opportunities to improve care
To insure that services are community based, consumer directed, culturally competent and outcomes focused

QUALITY MANAGEMENT SYSTEM STRUCTURE
The Quality Policy Committee (QPC) reports directly to the Director of Mental Health Services. Under the QPC is the System of Care Quality Improvement Committee (QIC). Under that are the following committees: Children's QIC, Adult QIC, Geriatric QIC, Risk Management QIC, Practitioner Review QIC, Pharmacy & Therapeutics Committee, Drug Utilization and Formulary Committee, Inpatient QIC.

WHO HAS INPUT INTO THE QUALITY MANAGEMENT SYSTEM?
Providers through the QIC's
Administrators through the System of Care QIC
Consumers and public through the QPC

QUALITY MANAGEMENT INDICATORS
Consumer Focus Indicators
Provider Focus Indicators
System Focus Indicators

All indicators are regularly reviewed through the Quality Management Committee Structure.

WHAT ARE THE CONSUMER FOCUS QUALITY INDICATORS?
- CONSUMER SATISFACTION
  - First year: CSQ-8—Anonymous
  - Second year: CSQ-8—With client identifiers
  - For the future:
    - NIMH's Mental Health Statistics Improvement Project (MHSIP)
      - Consumer Survey will be required by the State for adults
    - CSQ-8 required for children and youth for two years starting in 1998
    - Focus groups
- CONSUMER OUTCOMES
  - Children and youth

Collecting data on several instruments required by the State for two years starting July 1, 1998

Adults

Piloting several instruments as part of the State pilot

State will soon make decision on requirements

Plan to pilot Multnomah Community Ability Scale (MCAS) in SF

Older Adults

Statewide pilot effort just beginning

ACCESSIBILITY

I-888 Number Study—funded by the Center for Mental Health Services Research

Consumer survey of satisfaction with access

State-generated "penetration data"—of all eligible people on MediCal how many are served

QUALITY OF CARE REPORTING (Called incident reports by hospitals)

Required reporting of concerns by providers

Database of all concerns are maintained

Investigations by quality management staff and Risk Management Committee

Data is used to identify system wide trends and problems

COMPLAINTS AND GRIEVANCES

Complaints to programs are logged and submitted to Quality Management and reviewed though the Quality Management System

Grievances are tracked by Quality Management and reviewed through the Quality Management System

The data is used to identify system wide trends and problems

INTERFACE WITH PHYSICAL HEALTH CARE

Three age-specific consultation/liaison teams provide:

Psychiatric medication consultation to primary care clinics

Enhanced linkage & referral between primary care and mental health clinics

Quality management staff and team members evaluate success of these efforts

WHAT ARE PROVIDER FOCUS QUALITY INDICATORS?

MEDICATION AND PEER REVIEW

Annual reviews of cases for each psychiatrist

The review focuses on evaluation of safety and efficacy

CHART AND CASE REVIEW

For the System of Care, the age specific QIC's design and monitor the review activities of the Provider Utilization Review and Quality of Care Committees (PURQCs)

The PURQC's at the program level review charts and cases of each provider

PRACTITIONER REVIEW

The Practitioner Review Committee

Determines the initial and ongoing qualifications of providers for appointment and privileges in the Provider Network

Determines that the composition of the Provider Network meets the clinical and cultural needs of the clients

- PROGRAM REVIEW
  - Regular review of all CMHS providers
    - Requirements for the "organizational providers" are established
    - Requirements for the new network providers are being established
  - Completed by an independent consultant
- UTILIZATION MANAGEMENT AND SERVICE CAPACITY
  - Regular monitoring of service capacity (type and quantity) in relation to client population needs
  - Regular monitoring of clients' use of service to prevent under- or over-utilization

- WHAT ARE THE SYSTEM FOCUS QUALITY INDICATORS
  - SYSTEM INDICATORS
    - Annual evaluation by the QPC of the structure and process of the QM System
    - QPC prioritizes quality improvement focus areas and approves the Annual Quality Management Plan
  - QUALITY MANAGEMENT COMMITTEES
    - The entities that carry out the QM Plan
    - Founded on the principles of Continuous Quality Improvement (CQI)
    - Information and proceedings of some committees are "protected from discovery"
    - QPC annual review of progress
    - Composition and duties are specified for each committee
  - THE QUALITY POLICY COUNCIL
    - Focus on development of policy for quality management in CMHS
    - Includes:
      - CMHS Executive Group
      - Providers, Consumers, Family Members
      - Representatives of the Contractors' Association, Patients Rights Advocacy Services, Mental Health Board
      - Quality Management Staff
      - Interested members of the public
  - SYSTEM OF CARE QUALITY IMPROVEMENT COMMITTEE
    - Oversee quality for the entire CMHS system
    - Coordinate and integrate the activities of all the other QIC's
    - Prioritize data and information for presentation to the QPC
    - Assign tasks to the QIC's based on policy direction from the QPC
  - AGE SPECIFIC QIC's
    - Focus on the population by age
    - Includes age specific directors, providers, and quality management staff
  - RISK MANAGEMENT COMMITTEE
    - Focus on issues with significant clinical risk
    - Chaired by the CMHS Medical Director and includes representatives of each professional discipline
  - PRACTITIONER REVIEW COMMITTEE

Determines the initial and ongoing qualifications of providers for appointment and privileges in the Provider Network
Chaired by the Associate Director for Quality Management and includes representatives of each professional discipline

PHARMACY AND THERAPEUTICS
Focus on medication policy and practice
includes physicians, providers and quality management staff
Drug Utilization and Formulary Subcommittee

INPATIENT QUALITY IMPROVEMENT COMMITTEE
Members include quality management staff and contracting hospital representatives
Identify and act on quality improvement issues in inpatient settings
Monitor continuity of care issues between inpatient and community providers

Dr. McConnell added the following notes: Many of the committees are confidential and protected committees. Legally what happens in those committees is not discoverable, so practitioners are free to talk about problems without being afraid what they say will end up in court. Otherwise no one would ever admit they did anything wrong.

We want to know when anything in the system happens that shouldn't happen or is harmful. We investigate all deaths in the system whether we think the system had anything to do with it or not. This is mostly suicides. We review all suicides to make sure we understand why they happened.

We try to resolve complaints at the program level.

We work with Primary Care to help them deal with what they feel competent to deal with. When they don't feel competent to deal with something, they can refer the person to the mental health system.

Dr. Moses: Do you investigate attempted suicide? Dr. McConnell: Yes, we investigate attempts to try to figure out what might be going wrong, so we can possibly prevent suicide in the future.

We have hundreds of Network Providers, so we'll probably review a sample of them every year and a sample is good as long as it's truly random. We have independent reviewers who go out and do the review by the letter of the regulation.

Dr. Moses asked about grievances. Dr. McConnell: For clinics in our system, we investigate complaints. For network providers we collect complaints and when we do the annual credentialling review, we'll look at those grievances and take them into account.

We will soon be doing a study of the capacity of the system. This ties in with the Single Standard of Care. We have high-user reviews in all 3 sections. If clients are high users of services, they are probably not getting the right services.

Mr. Shipley: That's one reason Community Focus and the other Single Point of Responsibility programs were established, to have one treatment place for high users.

Ms. Leib: How many people work in Quality Management? Dr. McConnell: Six hundred if we count every staff person. But 18 if we only count staff specifically assigned to the Quality Management section.

Ms. Deger: I'm curious to know how things from the committees filter back. How are changes implemented? Dr. McConnell: If a policy decision is made at the Quality Policy Committee, then it's the job of the system to make sure it gets out to the front lines. It's really my job to make sure that happens and to make sure the information is flowing in from the front lines.

Ms. Deger: How often do the committees meet? Dr. McConnell: Almost all of them meet once a month. In the beginning it seemed like we had too many committees but we couldn't see what to cut out. They each have a job to do and they seem to be doing it.

Dr. Moses: Do you still chair the QPC? Dr. McConnell: Yes. Mr. Shipley: Did we ever get an ombudsman? Dr. McConnell: No.

III. CONSENT CALENDAR

RESOLUTION (MHB-98-31): Be it resolved that the minutes of the Mental Health Board meeting of October 14, 1998, be approved as submitted. (Passed)

RESOLUTION (MHB-98-32): Be it resolved that the Mental Health Board grant leaves of absence for the November 10, 1998, meeting to: Jim Beauford, Supervisor Sue Bierman, Peggy Gilleran, and Chet Villalba. (Passed)

RESOLUTION (MHB-98-33): Be it resolved that the Mental Health Board appoint former Board member Shawn Thomas as a member of the MHB's Adjunct Team. (Passed)

IV. DIRECTOR'S REPORT

No report.

V. MHB COMMITTEE REPORTS

Executive Committee

Ms. Planck: When Renee appeared before the Rules Committee this morning to be appointed to the Mental Health Board, she said she was interested in working with the

Board of Supervisors. Supervisor Ammiano, Chair of the Rules Committee, and incoming President of the Board, said: That's good, because mental health is really important. We are going to take care of the funding needs for mental health.

At the end of the afternoon, I passed this comment on to Jo Ruffin. She said she had just been at a reception where Supervisor Newsom said he wants to see mental health services funded. This appears to be good news for our hopes for providing a single standard of care.

Ms. Leib: Patients Rights Advocacy Services will be closing down in the spring. There's going to be a meeting on December 1st to discuss the future of patients rights advocacy in the mental health system.

Dr. McConnell: We plan to start a new contract for patients rights advocacy on April 1, 1999. Mr. Shipley: What are the options? Dr. McConnell: We have to meet the State requirements but otherwise we're open for any ideas about how to structure it. We'll probably put out an RFP. If anyone has ideas about organizations who could take on this work, please encourage them to apply. We hope we'll have several bidders.

Ms. Leib: The Mayor's Disability Council is looking for people to represent mental health. Thank you to Mickey Shipley for being the official MHB representative to the Quality Policy Committee.

Chet is representing us at the Joint Council of Advisory Boards. They are looking at ways to work together on issues that cross divisions like cultural competency. Mary Sue was at the last meeting and high level staff were present including Jo and Bob Prentice. They are hoping for some uniform reporting style to the extent that's possible.

The MHB retreat will be on Saturday, December 12, from 9:30-4. Thanks to Tim for representing us at the luncheon of the Disability Rights Education and Defense Fund. Thanks to everyone who did program reviews. Once again we've done a good job.

Committee on a Cultural Competency and Special Populations
Ms. Planck: We reviewed the presentation we had by the transgender group. This issue is something we're going to hand over to the Program and Services Committee. There are some questions we want to add to the program review on the transgender issue. We may recommend to CMHS that there be more training and sensitivity to gender issues throughout the system.

Mr. Agar: The Committee is going to be moving from the Board Room into the field, and do more hands on experience. Ms. Planck: We'd like to go to the Tom Waddell Clinic for a visit. The transgender presenters said that was the one place they felt safe. Mr. Agar: We also talked about neighborhood visits to look at services related to a neighborhood.

Program and Services Committee
Dr. Shue: We discussed the area of forensics and decided to look into that, do an in-depth investigation. Ms. Planck: We saw how big an area it is and decided to break it down into three sections: 1) police, 2) court system, and 3) jail. Dr. Shue: We decided to take that on as one of our areas. Also Attention Deficit Disorder. We also have an invitation from the Executive Committee to follow up on the issue of consumer employment in the mental health system.

Ms. Planck: When I recently visited a prisoner in the San Jose Jail, I found out their policy was that all mental health inmates had to have their hands chained to their waist for visits.

Consumer/Family Member Task Force
Mr. Adamek: At the last meeting we discussed the corrections to the Handbook as requested by the MHB Executive Committee. Ms. Leib: The Executive Committee will be meeting with the Task Force next week, then they will begin their 9-month probationary period.

Community Advisory Board, Department of Psychiatry, SF General Hospital
Mr. Shipley: The CAB is meeting tonight at the same time this meeting is taking place.

CMHS Committee on Culturally Competent Systems of Care
Ms. Chartrand: Claire Skiffington made a presentation on transgender issues. The agenda for the upcoming year includes: A Transgender Forum; a conference on African American Clinical Issues, organized by Bruce Williams and Gary Zomalt; a training in March on how to use interpreters; a conference later on focusing on the Russian population. In January the Committee will have its retreat.

Dr. Moses: I was invited to the Family Mosaic Open House on Saturday. We have a great Director there doing great work. We could have him come to the Board and make a presentation.

V. PUBLIC COMMENT
Mr. Adamek: What I caught of Bill's presentation was excellent. I'm sorry to hear that Patients Rights Advocacy Services is going out of business. I hope CMHS makes it a top priority to get a replacement so mental health consumers will have a place to go when they have a problem.

VI. ADJOURNMENT
Dr. Moses requested that the meeting be adjourned in memory of the homeless people who had been killed over the last few days. There being no further business, the meeting was so adjourned at 8:25 p.m.

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The Mental Health Board meeting scheduled for December 9, 1998, has been CANCELED

The Board will be holding its Annual Retreat on Saturday, December 12, 1998.

No action items are on the agenda for the Retreat. Any proposals or recommendations developed by the Board during the Retreat will be voted on at its next regular meeting on **Wednesday, January 13, 1999**.

An agenda for that meeting will be sent out at the beginning of January.